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SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE FULL BOARD

Wednesday, January 13, 1999
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS

II. CONSENT CALENDAR See Attachment A

A. Approval of November Minutes
B. Approval of Leaves of Absence

III. TRIBUTE TO MARY SUE PLANCK

Our beloved Executive Director, Mary Sue died unexpectedly on Tuesday, January 5, 1999. She had been with the Board for 14 years and had served as the Executive Director for 6 years. Board members and the public will be invited to share thoughts, feelings, memories, poems, and other tributes.

Items of Board business may be taken up following the tribute, however these items may also be deferred until the February meeting.

IV. MHB RETREAT: Discussion of Action Priorities for 1999

See Attachment B

V. MHB COMMITTEE REPORTS, OTHER COMMITTEES

- Executive Committee, Chair's Report
- Children's Committee
- Cultural Competence/Special Populations
- Program and Services
- Consumer/Family Member Task Force
- SFGH CAB
- CMHS Committees, MHB Representative Reports

VI. PUBLIC COMMENT PERIOD

VII. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

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MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

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UNADOPTED MINUTES

Wednesday, January 13, 1999, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Tim Agar; Jim E. Beauford, Ph.D.; Supervisor Sue Bierman; April Martin Chartrand; Renee Deger; Darwin Dias; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Brian Peagler; Gloria Samayoa; Mickey Shipley; Sylvia Shue, Ed.D.; Lora Traveler, M.A.; Chester Villalba; Barbara Williams.

BOARD MEMBERS ON LEAVE: none

BOARD MEMBERS ABSENT: none

ADJUNCT BOARD MEMBERS PRESENT: none.

OTHERS PRESENT: An additional 50+ people were present.

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:40 p.m. There was consensus to postpone all Board business until the February meeting.

II. TRIBUTE TO MARY SUE PLANCK

Mary Sue Planck, beloved Executive Director of the Mental Health Board, passed away unexpectedly on January 5, 1999. Board members, colleagues, and friends spoke about their memories of Mary Sue, how she inspired them, and how her memory will live on in their lives.

III. ADJOURNMENT

There being no further business the meeting was adjourned at 7:35 p.m.

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MEETING OF THE FULL BOARD

Wednesday, February 10, 1999
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minute
II. CONSENT CALENDAR See Attachment A A. Approval of November Minutes B. Approval of janaury Minutes C. Approval of Leaves of Absence	5 minutes
III. DIRECTOR'S REPORT	15 minutes
IV. **MHB RETREAT: Discussion of Action Priorities for 1999** See Attachment B (mailed in January)	60 minutes
SHORT BREAK	5 minutes
V. COMMITTEE REPORTS • Executive Committee, Chair's Report • Children's Committee • Cultural Competence/Special Populations • Program and Services—Action Item—See Attachment C • Consumer/Family Member Task Force • SFGH CAB • CMHS Committees, MHB Representative Reports	20 minutes
VI. PUBLIC COMMENT PERIOD	10 minutes
VII. ADJOURNMENT	

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UNADOPTED MINUTES

Wednesday, February 10, 1999, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D. (Acting Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Renee Deger; Darwin Dias; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Sylvia Shue, Ed.D.; Lora Traveler, M.A.; Chester Villalba; Barbara E. Williams.

BOARD MEMBERS ON LEAVE: Tim Agar; Maria Leib; Supervisor Sue Bierman; Gloria Samayoa.

BOARD MEMBERS ABSENT: Brian Peagler.

ADJUNCT BOARD MEMBERS PRESENT: None.

OTHERS PRESENT: Collins Munns (CMHS); Louise Rogers (CMHS); Mike Wise (Consumer/Family Member Task Force); Emeric Kalman (Family Member); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Acting Chair, at 6:37 p.m. Barbara Williams, a new member of the Mental Health Board, was introduced. She was appointed by Supervisor Sue Bierman to a Consumer Seat.

II. CONSENT CALENDAR

RESOLUTION (MHB-99-01): Be it resolved that the minutes of the Mental Health Board meeting of November 10, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-99-02): Be it resolved that the minutes of the Mental Health Board meeting of November 10, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-99-03): Be it resolved that the Mental Health Board grant leaves of absence for the February 10, 1999, meeting to: Tim Agar; Supervisor Sue Bierman, Maria Leib, and Gloria Samayoa. (Passed)

III. DIRECTOR'S REPORT

Collins Munns introduced Ms. Rogers to report on the situation with the budget for the Department of Public Health for fiscal year 1999/2000.

Ms. Rogers: When we began the Mental Health Plan last April 1st we were committed to a Single Standard of Care, so that people with Medi-Cal and without Medi-Cal will receive a similar range of services. Partly through the efforts of the Mental Health Board, the Health Commission passed a resolution supporting the Single Standard of Care.

In the early months of the Mental Health Plan, we reported back how things were going. We were receiving so many applications for service that it looked like CMHS was going to have a deficit. In October it looked like we needed a Supplemental Budget Request. Sue Bierman, especially, took an interest in this and has been asking the Department of Public Health for several months to submit a request for a Supplemental.

Now we have data through December 1998 which shows a significant decrease in applications. The latest data do not indicate that we will have a deficit due to treatment costs, but they do indicate a deficit in pharmacy costs. We're now trying to figure out what a Supplemental will look like. It will probably ask for pharmacy funds only, and that amount will probably be annualized.

We've looked at why our projections for treatment costs dropped. The number of calls have dropped. This is not surprising in that we haven't done concerted outreach. We have plans for that, but they have been delayed.

We make a lot of referrals for treatment, but in the end providers are not billing for all the treatment authorized. Thirty percent of referrals are not connecting to treatment. Quality Management will do a survey to try to find out why people don't make the connection. We're authorizing the amount of treatment we think makes sense. Clients may show up for only a few visits.

Ms. Traveler asked why there was pharmacy deficit. Dr. Beauford: Is the 30% rate of not using authorized treatment also include the pharmacy? Ms. Rogers: The pharmacy services all clients across the system. The deficit is for the whole pharmacy service, but we cannot figure out if it's a result of new prescriptions or if it's just that the costs have been going up and we've been switching people to newer medications which are more expensive. It may also be true that people are being authorized for treatment, but are accessing only the pharmacy services.

Dr. Beauford: Lots of HMO's are reducing their formularies. What about CMHS? Ms. Rogers: We've been progressive—trying to get more people on the newer medications.

Dr. Shue: With regard to the 30% who do not connect to treatment, what's the breakdown between Medi-Cal and uninsured clients? Ms. Rogers: We looked at that.

There are not more Medi-Cal or more uninsured failing to connect to treatment. Also the providers are taking a long time to bill us—up to four months. So our data get weaker toward the end of the year.

Ms. Williams: Does the pharmacy deficit include San Francisco General Hospital? Ms. Rogers. SFGH operates their own pharmacy. The CMHS pharmacy budget is separate from that.

Mr. Wise: Are there any efforts to shift people who are eligible on to Medi-Cal? Ms. Rogers: We're trying to figure out if people on the pharmacy list are eligible so we can try to get them on Medi-Cal. There are probably at least 1,000 people served by the pharmacy who seem to be uninsured.

Dr. Moses: Sometimes the doctors don't have time to explain to patients how to use the medications and what the side effects are. Could CMHS have something like the patient education that is done by Kaiser? Ms. Rogers: I don't know. I can check with Dr. Forster about that.

Mr. Munns: I'd like to focus the rest of the Director's Report on the budget being submitted to the Mayor's Office on February 19th. This is a somewhat bleak year with regard to the budget.

There are significant revenue short falls in the institutions of the Community Health Network, such as Laguna Honda and San Francisco General Hospital. This shortfall is being managed by requesting General Fund monies, and through some significant expenditure reductions. But that won't take care of the shortfall.

DPH is working on longer range strategies by de-emphasizing long term care at SFGH and Laguna Honda and emphasizing community care. This is a profound policy shift.

When DPH is in fiscal trouble, Community Mental Health Services is also in fiscal trouble. DPH has taken the stance that it must bring its budget into line.

Mental Health will lose 6 positions permanently. There is a reduction of $4 million over all from the previous year. All of this information is subject to change by the actions of the Health Commission, the Mayors Office, and the Board of Supervisors. I doubt that there will be major changes, but there could be substantial shifts depending on what the Mayor does.

The Mayor's budget instruction was to submit only the baseline budgets with no new initiatives.

For Mental Health, the good news is that we are included in the expansion of funding for children. This depends on the Mayor's Office, but it looks like there is a commitment to increase funding for children in physical health, mental health, and social services.

Over the last 2-3 years we've had a Medicare reduction of $4 million from $5 million down to a projected $1 million. We've taken some initiatives to try to exceed $1 million in Medicare reimbursements. We've been doing training and restructuring of billing in response to the new rigorous standards Medicare has for billing.

With regard to institutional care, a significant problem is that at any given time, 20% of acute care beds are occupied by people who aren't really acute. The problem is the shortage of housing, the shortage of safe places to discharge people to. CMHS has been struggling with this for years. There is a serious need for the Department of Public Health and the City to expand housing. You may want to invite Mark Trotz, DPH's Housing Director, to come make a presentation to the Board.

The initiative which is responding to this situation is Crisis Case Management. This is a program to prevent people from recycling through emergency services.

We're talking about adding a CRT—Crisis Resolution Team. We're redirecting 3 positions to this program.

For CMHS, 6 positions have been lost under the budget proposal. For DPH there are 40-50 positions lost.

We're starting a pilot project on February 15th at Psychiatric Emergency Services to see if we can keep people out of emergency services. We'll have a PES staff work with the CRT to hook people up with Crisis Case Management. If this pilot doesn't work then we need to find something better.

Ms. Traveler: With regard to the institutional shortfall and moving people out to community alternatives, do you remember in the 70's when Ronald Reagan de-institutionalized people and sent them back into the community? What happened was it didn't work. There wasn't enough support for people.

Mr. Munns: The reason the de-institutionalization didn't work was that no money was sent to the counties. The Reagan Administration had no intention of helping the clients. It was a tactical decision. It had nothing to do with patient needs.

What we are doing is redirecting money away from the institutions because they take up most of our money. We can never have adequate community based services if we're supporting institutions at such a high level.

Mr. Villalba: It's great to hear your summary so nicely pulled together. We really need to spend some time in dialogue about the dilemmas and the positives. Since you have to cut $4 million from Mental Health, how is that decision made?

Mr. Munns: The final decision making is from Dr. Katz, but that decision rolls up from the Directors and the Division level to him. The allocation was made to the Divisions based on the shortfall. CMHS is 50% of the Population Health Division, so it took 50% of the shortfall reduction.

Mr. Villalba: What about the Department of Psychiatry at San Francisco General Hospital? Mr. Munns: That Department is under a separate budget, although they do receive money from CMHS.

Mr. Villalba: Does the Community Services item come out of the Mental Health budget? Mr. Munns: Three positions were redirected, so there is no fiscal impact. Money for inpatient services was redirected to support the CRT. But shifting those dollars means that we must be able to reduce the need for inpatient services, because we're already using those inpatient dollars.

Mr. Villalba: I'm concerned about how we're dealing with the homeless, as the police pick them up and put them in the inpatient services. If housing and alternative care are is in such short supply, how is the system going to respond? Mr. Munns: Through greater supportive housing. Mark Trotz is generating new initiatives. But this will still not be enough. The City is purchasing a 30-unit hotel to create new supportive housing. The City is attempting to create 100's of beds for people now in acute care.

Mr. Shipley: I'm a little concerned because I've been out there; I was homeless, and now I'm one paycheck away from it. I'm concerned that the City will not spend money on housing because it's facing a serious deficit. At the same time there is new pressure for the police to pick up the homeless.

Dr. Shue: What's the reason for the reduction of Medicare from $5 million to $1 million? Mr. Munns: What's happened with Medicare is due to the Balanced Budget Act of 1997, there are changes in Medicare. Much of the balance in that Act is at the expense of Medicare. There was a clear mandate to reduce Medicare. So they've put into place draconian standards. Now many services are experiencing a 90% reduction of claims and even the 10% of claims that come through, often have to go through an appeals process. We are having to retrain staff on how to meet the regulations. This is a system that's going to get worse before it gets better. Much of the surplus in the federal budget is coming from savings in Medicare.

Community based services have not had the chance to prove what they can do, because so much of the resources have been taken up by institutions. Mickey is right about housing in the City. I think San Francisco is going to have to look at housing outside of the city.

Ms. Williams: You don't have to be mentally ill to end up on the street, but if you end up on the street, that can make you mentally ill. What is the cost difference between inpatient and diversion? Mr. Munns Acute inpatient costs between $700 and $1,100 per person per day. Acute diversion casts $240 per day. Ms. Williams: Does CRT work with the police? Mr. Munns: Only as needed and requested. Lots of cases don't require police intervention.

IV. MENTAL HEALTH BOARD RETREAT

> **RESOLUTION (MHB-99-04): Be it resolved that the Mental Health Board adopt as its first priority for its work in 1999 the following: Advocate for the enhancement of target programs to bring care to the minimally treated and homeless.**

Mr. Villalba then recommended that this priority be assigned to the Cultural Competency and Special Populations Committee, first, since Program and Services is already working on the issue of mentally ill offenders and the criminal justice system and second, since the minimally treated and homeless could be considered a special population. The decision was made to do so.

Priority #2 was postponed because it required a larger discussion. Priority #3 was taken up next.

> **RESOLUTION (MHB-99-05): Be it resolved that the Mental Health Board adopt as its third priority for its work in 1999 the following: Develop specific contacts and forums to do more high visibility outreach to treatment programs, consumers, and family members.**

Ms. Chartrand illustrated this Priority by talking about the visit of the Cultural Competency and Special Populations Committee to the Tom Waddell Clinic earlier in February. She said it was a two way interchange, the Mental Health Board learned about them and they learned about the Mental Health Board. She said she thought it would be good to continue such visits as "hands-on PR." She said she felt it would be good for Board members' own education and personal development, and recommended that every Committee make an effort to get out in the community.

Ms. Gilleran: Last year the Governor signed into law a bill to fund counties to develop local action plans to reduce the number of mentally ill offenders in jails and prisons and to cut down on the number of offenses, to provide treatment for offenders while incarcerated, and to provide aftercare.

Our County is putting together a plan under Sheriff Hennesey's guidance, for a 3-4 year grant. There is a short time line for the development of this grant. In response, the Program and Services Committee held a meeting and invited all Board members as well as other advocacy groups to join us. We gave suggestions to Gibson and Associates, the firm which is contracted to develop and write the grant for the Sheriff's Department. Those suggestions are in the Resolution in Attachment C.

RESOLUTION: (MHB-99-06):

WHEREAS the Mental Health Board of San Francisco determined in its annual planning retreat in December 1998, that services for mentally ill offenders would be the Board's top priority for 1999, and

WHEREAS the Board has determined that there is an urgent need for additional services for mentally ill offenders, and

WHEREAS the Board recognizes that it is crucial that there be excellent coordination between City departments and other agencies in order to provide effective treatment, care, and support to each mentally ill offender, now, therefore,

BE IT RESOLVED that the Mental Health Board of San Francisco endorses the Sheriff's Department proposal for a Mentally Ill Offender Crime Reduction Grant through the Board of Corrections, State of California.

BE IT FURTHER RESOLVED that the Mental Health Board gives its full endorsement to the following principles and proposals with regard to the Mentally Ill Offender Crime Reduction Grant, specifically, and in the development of the larger system of services for mentally ill offenders, in general:

> **1) A permanent, interdepartment, interagency Steering Committee is necessary to insure the effective operation of services and to insure the seamless transition of individuals from one service to another, as well as from the community to incarceration and from incarceration back to the community. The Mental Health Board would be very interested in having a representative of the Board serve on the Steering Committee.**
>
> **2) A specialized intensive case management program focused solely on mentally ill offenders is essential for the coordination of services. Such a case management program cannot be limited in scope just to treatment issues, but must be capable of responding to the full range of life issues which challenge mentally ill offenders. Such case management needs to include an effective system of pre-release planning and action well in advance of the release date.**
>
> **3) A special court needs to be developed focusing on mentally ill offenders and providing special training to judges and lawyers involved in the operation of that court.**

4) Access to affordable housing for mentally ill offenders needs to be developed. This includes the development of specialized residential treatment facilities.

5) A specialized entry point into the criminal justice system, and alternative to the jail itself or Psychiatric Emergency Services, needs to be established so police will have somewhere appropriate to take mentally ill offenders for triage immediately upon arrest.

6) Programs of outreach to mentally ill offenders and their families are needed. Special attention needs to be given to the children of offenders so that they do not follow the life pattern of an offending parent.

7) Special attention needs to be focused on first time offenders to reduce the likelihood that they will become repeat offenders.

8) A long-term, stable system for responding to mentally ill offenders needs to be put in place as an alternative to shifting the responsibility from mental health to criminal justice agencies and back again every few years.

9) The State of California needs to make a commitment to follow up the lessons learned from the Mentally Ill Offender Crime Reduction Grant with continuing and increased funding sufficient to establish programs and systems such that each county in California will have the capacity to serve each and every mentally ill offender effectively.

10) Finally, the Mental Health Board would like to emphasize, in the context of the clinical and systemic developments above, the underlying importance of the personal relationship of providers of services to the mentally ill offenders.

It is crucial that the staffing structures be designed very specifically to support treatment effectiveness. Long-term, stable staffing can produce results that short-term, constantly rotating, high-turnover staffing cannot produce. Overwhelming case loads preclude the possibility of treatment effectiveness. Clients with severe trust problems cannot develop trust in a sporadic and changing flow of staff persons.

The one factor which promotes healing in mentally ill persons is a relationship with an individual who genuinely cares about them and whose caring is reflected in their professional work with the client. It is clear from studies of child development that human beings learn self respect from being respected and cared for.

> **Therefore the treatment relationship must be both well-designed and well-supported. Just as our treatment systems need to be more effective at caring for our clients, so they also need to be more effective at supporting the staff. Conditions which lead to burn out compassion fatigue f and resulting staff turn over must be analyzed and corrected**
>
> **We do not refer here to "coddling"—either offenders or staff but rather to effective treatment, respect for the human dimension of the work, and accomplishment of the healing goal.**

Ms. Gilleran: The law that establishes this grant does not want the money to be spent on jail diversion. So using that terminology will not put us in favor for getting these funds. Also the issues we hope to address are much more comprehensive than just the issue of diversion. Therefore, I'd like to recommend alternative language for our Priority #2.

> **RESOLUTION (MHB-99-07): Be it resolved that the Mental Health Board adopt as its second priority for its work in 1999 the following: Advocate for and support a program of prevention and intervention for individuals at risk of involvement with the criminal justice system.**

Ms. Gilleran: I want to note that we have a power house of a Board. Since the loss of our dear friend and Director, Mary Sue, we have operated at full strength and have made good progress.

V. MHB COMMITTEE REPORTS

Executive Committee

Ms. Gilleran: The meeting was dedicated to our MHB transition plan, given our staffing gap. The Search Committee for a new Executive Director is: Jim Beauford, Chet Villalba, Maria Leib, and Rich Snowdon.

Children's Committee

Dr. Beauford: We're focusing on the relationship between mental health services and Special Education. We had a presentation from the Parent Involvement Program. We'll be meeting with Dr. Pat Anderson of the School District on March 17th.

Committee on a Cultural Competency and Special Populations

Mr. Villalba: We visited the Waddell Clinic and met with the staff and consumers. There was a wonderful feeling throughout the whole clinic. April was wonderful in her ability to communicate, and Tim knew alot about this area through is work at Glide.

Program and Services Committee

Dr. Shue: The last two meetings, we've focused on the criminal justice system.

Consumer/Family Member Task Force

No meeting.

Community Advisory Board, Department of Psychiatry, SF General Hospital
Mr. Shipley: We had a presentation on the new crisis case management program. I have resigned as Chair of the CAB.

CMHS Quality Policy Committee
Mr. Shipley: We followed up on a letter from the MHB to CMHS about informing clients of their rights and about medication issues. A new policy is being developed.

CMHS Committee on Culturally Competent Systems of Care
Ms. Chartrand: The African American Conference on mental health is coming up. Key presenters include: Bruce Williams, Donald Tarver, and Gary Zomalt. I'll be presenting poetry.

Ms. Gilleran: I want to announce that one of our Board members and one of our Adjunct members have been honored by statewide organizations:

Mickey Shipley has been elected Secretary of the California Association of Local Mental Health Boards.

Steve Leoni is now President-Elect of the Mental Health Association of California. He'll serve a two year term as President-Elect and then will become President.

V. PUBLIC COMMENT

Mr. Kalman: I think we're all aware of what's happening here in San Francisco, I'm basically talking about homeless people. I don't know what can be done to make any improvement in what's going on. It's tragic. The problem is that the public is against the homeless. Opinion is turning worse against the homeless. We have to involve everybody who is able to write to the papers and the Supervisors.

VI. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:53 p.m.

DPH

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MEETING OF THE FULL BOARD

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A A. Approval of February Minutes B. Approval of Leaves of Absence for March	5 minutes
III. DIRECTOR'S REPORT In addition to the regular report, Maria Poulo will be present with a special report on the new Client Billing System which is required by the State.	30 minutes
IV. PLANS FOR ACCOMPLISHING MHB PRIORITIES	45 minutes
SHORT BREAK	5 minutes
V. COMMITTEE REPORTS • Executive Committee, Chair's Report Budget Resolution—Attachment B Letter regarding Patients Rights Advocacy Services—Attachment C Future presentations at Board meetings—Attachment D • Children's Committee • Cultural Competence/Special Populations • Program and Services Police Crisis Intervention Program—Attachment E • Consumer/Family Member Task Force • SFGH CAB • CMHS Committees, MHB Representative Reports	20 minutes
VI. PUBLIC COMMENT PERIOD	10 minutes
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MENTAL HEALTH BOARD OF SAN FRANCISCO

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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UNADOPTED MINUTES

Wednesday, March 10, 1999, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D. (Acting Chair); Jim E. Beauford, Ph.D.; Supervisor Sue Bierman represented by Millicent Bogert; April Martin Chartrand; Renee Deger; Darwin Dias; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Chester Villalba; Barbara E. Williams.

BOARD MEMBERS ON LEAVE: Maria Leib; Brian Peagler; Sylvia Shue, Ed.D.

BOARD MEMBERS ABSENT: Tim Agar; Gloria Samayoa; Lora Traveler, M.A.

ADJUNCT BOARD MEMBERS PRESENT: None.

OTHERS PRESENT: Jo Ruffin (CMHS); Collins Munns (CMHS); Maria Poulo (CMHS); Mike Wise (Consumer/Family Member Task Force); Emeric Kalman (Family Member); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Acting Chair, at 6:42 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-99-08): Be it resolved that the minutes of the Mental Health Board meeting of February 10, 1999, be approved as submitted. (Passed)

RESOLUTION (MHB-99-09): Be it resolved that the Mental Health Board grant leaves of absence for the March 10, 1999, meeting to: Maria Leib, Brian Peagler, and Sylvia Shue. (Passed)

III. DIRECTOR'S REPORT

Ms. Ruffin reported as follows: There are major shortfalls in the budget, so a freeze has been placed on positions in general and some specific positions have been cut. It's possible there will be some program cuts.

The Department's proposal for those cuts will be presented to the Health Commission at a special session on March 23rd. I have not made any program cuts, but I have been asked to make administrative cuts and am in the process of preparing those.

It's critical that there be support for the maintenance of safety net services within the Department of Health. One of the reasons for the deficit is the numbers of indigent clients being served by San Francisco General Hospital and Laguna Honda.
Ms. Deger: Don't the indigent qualify for coverage? Ms. Ruffin: No, but we work hard at getting people onto Medi-Cal and have been quite successful. But there are people who are not eligible, such as the working poor.

I will be having two hip replacement operations—one in early May and a second one in late fall. I'm scheduling them around the budget process. I'm doing okay, and there is a good prognosis for the outcome of these procedures. Collins will be in charge of the Service while I'm away.

Mr. Shipley: I'm concerned about Patients Rights Advocacy Services. The old organization is closing at the end of the month and there still is nothing new in place. Ms. Ruffin: The Board of PRAS gave us notice that they were going out of business. We put out an RFP and received two responses. However, in reviewing them, there were a number of questions raised. I'm interested in having a good solid consumer advocacy program. The responses to the RFP were not particular enough in that area. Other models were proposed. At this point, we've decided not to accept the proposals we've received and will do the RFP again and make those issues clearer.

So the process will go past the shut down date of the current PRAS. We are making arrangements through an independent fiscal contractor to hire two advocates and have the phones switched over . We'll continue to assess the volume of calls. If there are too many for the two advocates to handle then we'll follow up on that.

Ms. Ruffin then introduced Ms. Poulo to report on the new Client Billing System, which she did as follows: We have always been required by the State Department of Mental Health to bill clients for services under the UMDAP (Uniform Method for Determining Ability to Pay) guidelines according to their ability to pay. We have been told by our Director to do what we can to increase revenues, give the current budget shortfalls.

Since Managed Care started, we've expanded our target population and are seeing many uninsured people who work but who do not have coverage. There's been a lot of strain on our clinics. We're hoping that this new revenue will help support programs. But we don't know how much revenue we'll generate. We haven't done client billing for the past 9 years.

Ms. Ruffin: The State is insisting on us collecting this money. We haven't done this in the past because the amount has been so small that the cost of billing has been greater than what we would have taken in. Clients may ask you why after all this time, this billing is starting to happen, and we wanted you to be informed.

If a person is on SSI and Medi-Cal, there is no liability. If the person is indigent and has no income, there is no liability. So this mostly covers the working poor. We have to make sure they get their services regardless of their ability to pay.

We plan to send statements to people who have over $500 in UMDAP liability. For anyone who has a smaller amount of liability, they would be charged directly by the clinics. We are not being given any additional resources to do this billing.

Ms. Deger: How much will it cost? About $30,000 to revise the billing program for our computer system. It costs $450 for a case of 100 billing statements including postage. This money is currently not in the budget.

Ms. Deger: Will this realistically pay for itself? Ms. Poulo: Yes, other counties have shown a return. We're estimating perhaps $150,000 for San Francisco.

Mr. Shipley: In writing off the old UMDAP liabilities won't the system be losing money? Ms. Ruffin: For 9 years there has been no billing, and we felt it was unfair to hit people with a bill of that size. We wanted to notify people before we start billing. We'll be starting the billing as of January 1, 1999.

Ms. Poulo went through the technical guidelines and procedures for the new billing system. She and Ms. Ruffin offered to be available to answer questions on this issue in the future.

IV. PLANS FOR ACCOMPLISHING MHB PRIORITIES

Ms. Gilleran led the discussion off by asking everyone to be creative in brainstorming ideas for action plans.

Priority #1: Advocate for the enhancement of target programs to bring care to the minimally treated and homeless.

Ms. Deger: I'd be curious to find out how we're working with Glide and St. Anthony's.
Mr. Shipley: Also the Coalition on Homelessness and the McKinley Center.
Mr. Villalba: This is a very big issue with lots of dimensions. We want to be thorough.

Ms. Ruffin: You may want to start with a CMHS staff presentation on what we're doing now as a foundation. Blanche Korfmacher would be a good person for this since she is the coordinator for homeless services. Also Barbara Garcia would be good since the Mission Rock Shelter is under the Department of Public Health.

Ms. Gilleran: It would be great to know first what CMHS is doing. It would be good to have fuller knowledge of what's going on in the community, so we're not operating as a satellite, and we can see where the gaps in services are.

Mr. Villalba: It's such a loaded and dramatic issue in some ways, it would be good to gather all the information first. Mr. Shipley: That's what Jim is doing with the Children's Committee, gathering all the information first.

Ms. Ruffin: Tina Yee is Director for Cultural Competency and Consumer Affairs which also ties in with this. My staff is available to your committees, not just for presentations, but in other ways as well.

Priority #2: Advocate for and support a program of prevention and intervention for individuals at risk of involvement with the criminal justice system.
Ms. Ruffin: We can pull together some people to share the state of the art of the relationship between Jail Psychiatric Services and Community Mental Health Services.

Ms. Gilleran: This is a huge field of exploration. We'll be dividing it into segments. One possibility is to bring in Jo Robinson from Jail Psychiatric Services, who is a most informed and deeply involved person in this area. We made bold recommendations in our resolution on the Sheriff's Department Grant, such as creating a special Mental Health Court.

Ms. Deger: I think we should invite Terence Hallinan. Mr. Shipley: Also Sheriff Hennessey.

Ms. Ruffin: There is the Planning Group which prepared the proposal for the Sheriff's Dept. Grant. That group is also charged with pulling together the coordination of services. I'd urge you to invite people from that group.

Ms. Williams: Do we have a DUI Court? Ms. Gilleran: Yes. Ms. Williams: That works
well? Ms. Gilleran: To me it seems so obvious the value of a court where all parties are
familiar with the special problems of the mentally ill. It's almost inhuman not to have
Mental Health Court. In Los Angeles they don't have a special court, but a special tea
The system should be set up so that when a mental health consumer comes in contact
with the criminal justice system, that automatically triggers the connection to the spe
court, instead of the consumer having to make a special application.

Dr. Beauford: We could schedule our presentations to coordinate with the priorities
the year. Mr. Villalba: The Committees handling each priority could select whom th
like to bring to the full Board. Ms. Deger: I'd like to hear about what we do for chil
in this city. Dr. Beauford: The Children's Committee is planning to hear from peop
and present our findings to the Board.

It was decided that the Program and Services Committee would prepare one or m
Board presentations on criminal justice issues, and the Cultural Competency and
Special Populations Committee will prepare one or more Board presentations on
health services for the homeless population.

V. MHB COMMITTEE REPORTS

Executive Committee

RESOLUTION (MHB-99-10):

WHEREAS, the decrease in revenues projected by the Department of Public Health for fiscal year 1999/2000 are due largely to events beyond the control of the Department, and the people being served by the Department, and

WHEREAS, federal and state government is shifting costs to local government by disallowing claims for Medicare and Medi-Cal at a remarkable and unprecedented rate and

WHEREAS, the housing crisis in San Francisco is related to the medical crisis, in that people who are unable to retain affordable housing are generally unable to stabilize and improve their medical conditions let alone prevent further deterioration, and

WHEREAS, an extraordinary number of people in our society are uninsured or underinsured, and many private companies are not providing adequate coverage, and

WHEREAS, the budget projections for Community Mental Health Services are based on the 1998/99 level of requests for treatment, a year in which there was essentially no outreach to the community of eligible people, and whereas, it is known that the need is far greater than the current level of requests indicates, and whereas, there may well be a significant increase in requests during fiscal year 1999/2000, and

WHEREAS, San Francisco currently enjoys a budget surplus, refuting the claim that there are insufficient funds to take care of those in need of assistance, and

WHEREAS, Community Mental Health Services, in particular, and the Department of Public Health, in general, have made significant strides forward in the past year in instituting cost-effectiveness and treatment effectiveness measures, such as the ACCESS line, the Single Point of Responsibility programs, and the increased use of state-of-the-art medications, and to interrupt or impede that progress in any way would not make good business sense, and

WHEREAS, it is crucial that there be continued maintenance of safety net services within the Department of Public Health, and

WHEREAS, the Mental Health Board believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community, now therefore,

BE IT RESOLVED, that the Mental Health Board of San Francisco urges in the strongest possible terms that the Mayor, the Board of Supervisors, and the Health Commission, at a minimum, support the funding of the following "Above Base Budget Needs" in the budget of the Department of Public Health for the fiscal year 1999/2000:

Replacement of Programs—Lost Grants	0.6 million
Workers Comp	2.0 million
Program Enhancements—Substance Abuse	1.0 million
Program Enhancements—Mental Health	1.0 million
Cost of Living Increases	7.0 million
Ryan White Mental Health Services	.5 million
HAAS Grant B	.06 million
HIV Post-Exposure Prophylaxis	.1 million
TOTAL	12.26 million

(see page 6.33 of the DPH Budget Proposal) and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City of San Francisco appropriate $400,000 from the General Fund to make up for a reduction in Medicare revenues for mental health inpatient services, (see page 6.21 and 6.42 of the DPH Budget Proposal) and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City of San Francisco provide $261,913 for the operation of the SSI Advocacy Unit of the Department of Public Health, a program with an estimated 60% success rate, saving the City at least $621,000 in General Assistance costs and $765,000 in Medi-Cal costs, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City of San Francisco add an additional $2 million to the line "Program Enhancements—Substance Abuse" and an additional $2 million to the line "Program Enhancements—Indigent Mental Health," to be prepared for an increase in homelessness, the current medical crisis, and requests for service, and

BE IT FURTHER RESOLVED, the Mental Health Board urges that the Mayor, the Board of Supervisors, and the Health Commission to mobilize all the contacts, persuasiveness and political power available to them to:

1. End the runaway rental increases in San Francisco, which are making housing unaffordable even for middle class families, let alone the poor and indigent and those living on fixed incomes,

2. Undertake even greater initiatives to create various levels and kinds of supportive housing for those in need,

3. Convince federal and state government to reverse their unfair, draconian policies about disallowing Medicare and Medi-Cal reimbursements,

4. Take all possible measures to insure that private companies are providing adequate health insurance, so they won't "dump" their employees on the public health system for services which the private sector by rights should be covering,

5. Continue to support the call for a national plan to end homelessness, so that the larger factors which cause homelessness can be seriously and effectively addressed, and so that every state and municipality will be required to take responsibility for the needs of their homeless citizens, and thus cities such as San Francisco will not have to bear more than their fair share. (Passed.)

RESOLUTION (MHB-99-11): Be it resolved that the Mental Health Board ratifies the action of the Executive Committee in sending a letter to the Director of Community Mental Health Services on February 24, 1999, supporting the advocacy model of Patients Rights Advocacy Services. (Passed.)

Children's Committee
Dr. Beauford: We'll be meeting with Dr. Pat Anderson of the School District on March 17th. We've developed recommendations for her regarding the restructuring of Special Education. We're asking her to attend the monthly meeting of the Children's System of Care Council. We also want to make sure that all these people dealing with children are competent and well trained.

Committee on a Cultural Competency and Special Populations
Mr. Villalba: The Committee will be meeting on March 30th.

Program and Services Committee
No report.

Consumer/Family Member Task Force
No report.

Community Advisory Board, Department of Psychiatry, SF General Hospital
Mr. Adamek: Everything's going along quite well.

CMHS Quality Policy Committee
Mr. Shipley: We got quality improvement summaries of the data for the first two quarters for this fiscal year.

CMHS Committee on Culturally Competent Systems of Care
Ms. Chartrand: The African American conference was really good this year. It was well attended and had good presentations.

V. PUBLIC COMMENT

Mr. Diaz spoke on the issue of charges he's filed against psychiatry.

Mr. Adamek urged every to write the Governor against reducing the standards of the Lanterman, Petris, Short Act.

VI. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:40 p.m.

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MEETING OF THE FULL BOARD

Wednesday, April 14, 1999
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A A. Approval of March Minutes B. Approval of Leaves of Absence for April	5 minutes
III. VISIT WITH SUPERVISOR LELAND YEE	30 minutes
IV. DIRECTOR'S REPORT	30 minutes
SHORT BREAK	5 minutes
V. COMMITTEE REPORTS	35 minutes

- Executive Committee, Chair's Report
  - Attachment B: AB 88 (Thomson) Parity for mental helth coverage
  - Attachment C: SB 468 (Polanco) Parity for mental helth coverage
  - Attachment D: Kostanian, Civil Rights Vigil
- Children's Committee
- Cultural Competence/Special Populations
- Program and Services
  - Attachment E: AB 34 (Steinberg): Mentally ill at risk for homelessness or incarceration
- Consumer/Family Member Task Force
- SFGH CAB
- CMHS Committees, MHB Representative Reports

VI. PUBLIC COMMENT PERIOD	10 minutes
VII. ADJOURNMENT	

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

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UNADOPTED MINUTES

Wednesday, April 14, 1999, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Tim Agar; Supervisor Sue Bierman represented by Millicent Bogert; April Martin Chartrand; Renee Deger; Darwin Dias; Toye Moses, Ph.D., M.P.H.; Chester Villalba.

BOARD MEMBERS ON LEAVE: Jim E. Beauford, Ph.D.; Peggy Gilleran, J.D.; Brian Peagler; Gloria Samayoa; Mickey Shipley; Sylvia Shue, Ed.D.; Barbara E. Williams.

BOARD MEMBERS ABSENT: Lora Traveler, M.A.

ADJUNCT BOARD MEMBERS PRESENT: None.

OTHERS PRESENT: Jo Ruffin (CMHS); Collins Munns (CMHS); Rachel Pretinski; Mike Wise (Consumer/Family Member Task Force); Emeric Kalman (Family Member); Helynna Brooke; Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:40 p.m. She explained the change in agenda as follows: Several Board members called today to say they had come down with the flu. Several Board members had already scheduled leaves. Since it was clear that attendance would be light at tonight's meeting, I asked staff to call Supervisor Yee to see if he would mind postponing his visit with us until May or June when would hope to have most of our Board present. He graciously agreed.

II. CONSENT CALENDAR

RESOLUTION (MHB-99-12): **Be it resolved that the minutes of the Mental Health Board meeting of March 10, 1999, be approved as submitted. (Passed)**

RESOLUTION (MHB-99-13): **Be it resolved that the Mental Health Board grant leaves of absence for the April 14, 1999, meeting to: Jim E. Beauford, Peggy Gilleran, Brian Peagler, Gloria Samayoa, Mickey Shipley, Sylvia Shue, and Barbara E. Williams. (Passed)**

III. VISIT WITH SUPERVISOR LELAND YEE

Postponed as explained above.

IV. DIRECTOR'S REPORT

Ms. Ruffin reported as follows: The Supplemental Request for additional mental health funding was before the Finance Committee of the Board of Supervisors today. The Committee is chaired by Supervisor Leland Yee. The other two members are Supervisor Tom Ammiano and Supervisor Sue Bierman.

This Request was about addressing a problem we've had in mental health for a number of years. We've only had funding to serve the most seriously mentally ill, and have been criticized for limiting our services to that population. When the State created the mental health carve out under managed care, they consolidated the State run fee-for-service program with the County services. In the course of doing this the State created broader medical necessity guidelines which allowed us, and gave us funds, to serve all Medi-Cal recipients. But what the State didn't provide was funding for the indigent and under-insured population.

We presented this issue to the Department of Public Health and the Health Commission as a policy question and requested additional funding for a Single Standard of Care. The Department and the Commission were supportive. Since there are so many homeless mentally ill, the Coalition on Homelessness joined in this request, calling it treatment on demand.

It was estimated that there were 120,000 Medi-Cal recipients in San Francisco. A large number of them were indigent, a large number were minorities, and many had language issues. We originally estimated and the Coalition agreed that an additional $6 million was required to address those needs. However, the Mayor's Office gave us $1 million to start the Single Standard of Care. It was understood that this Single Standard would phase in.

This year we have been able to make it financially, but that has been because about 50% of the people calling for services failed to show for their appointments. Of the group covered by the Single Standard, there is a very high need for medications, especially the newer medications. We've had about 2,000 new indigent clients. It took a while to see the Pharmacy deficit because of delays in the billing process.

Negotiations were begun with the Mayor's Office about the continuation of the Single Standard. Meanwhile there was a major deficit of $25 million in the Health Department. Given the deficit how could we ask for money for a new initiative?

With Supervisor Sue Bierman and the Coalition on Homelessness, the Request was pared down to $200,000 for pharmacy costs and $1.2 million annualized for an outreach component starting in the next fiscal year. This Request was presented at the Finance

Committee today. The Mayor's Office objected to the request for an annualized increase. They did not want to be tied to a commitment in next year's budget.

There was excellent testimony from advocates, the Coalition, and the Mental Health Board. The Committee passed the pharmacy piece of the Request. Negotiations will continue in the future for the outreach and service component.

Ms. Leib: What's the outlook for next year. Ms. Ruffin: This huge deficit, mainly at the institutions, has meant that there is a hiring freeze. DPH in the current budget has asked for funds to offset the reduction of revenue. Medicare and Medi-Cal are not reimbursing the way they used to, and there has been an increase in indigent clients. DPH is asking for and expecting to get some help from the Mayor's Office on the revenue side, and is looking at how to reduce expenses. In addition to the hiring freeze, a number of positions have been permanently deleted. In the Community Health Network, we have had to give up almost 100 positions. I don't think anyone expects to get enough funds from the Mayor's Office to completely close the budget gap.

Mr. Villalba: I believe there are cuts statewide in Medicare and Medi-Cal. Ms. Ruffin: And nationally, too. All hospitals are facing this problem, as in the case of the recent deficit at Stanford/UCSF. Mr. Villalba: What can be done? Ms. Ruffin: Efforts are needed at the state and national levels. Dr. Katz has been very supportive of mental health services and has been supportive of the legislative efforts the Mental Health Board has been supporting.

Ms. Ruffin: I want to announce the Bob Prentice will be leaving as the Director of the Population Health and Prevention Division of DPH of which Community Mental Health Services is a part. Dr. Katz has appointed Barbara Garcia as the new Director after Bob leaves. Her management assistant Jim Stillwell will be acting Director of Substance Abuse Services. Dr. Katz also appointed Jimmy Loyce as his Assistant Director. Jimmy had been serving originally as the Integration Specialist. Dr. Katz has asked Mr. Loyce, Ms. Garcia, and Anthony Wagner to begin working on a plan to integrate all services. Ms. Garcia, once she starts the new position, will be interested in coming to meet you and get to know you and your concerns.

Ms. Leib: Haven't we just spent the last 2-3 years reorganizing Public Health? Are we going back? Ms. Ruffin: Yes, there was a reorganization under another Director. Ms. Deger: What does it mean that Bob is out? Ms. Ruffin: He's been a great advocate for mental health. He's done lots of work on homeless issues. He has a strong public health perspective and is an advocate for community-based services. I'm looking forward to working with Barbara. She comes from a very community oriented background. She is a strong advocate for mental health and substance abuse services and AIDS services. She is also a very good strategic planner.

Mr. Dias: It 's really incredible given the money we have in this country that we maintain the most primitive level of socialized medicine in the world.

V. MHB COMMITTEE REPORTS

Executive Committee

> **RESOLUTION (MHB-99-14): RESOLUTION: Be it resolved that the Mental Health Board of San Francisco strongly recommends that the City and County of San Francisco officially endorse AB 88 (Thomson) with the following condition: that no amendment be made to require copayment when an involuntary commitment is made. (Passed)**
>
> **RESOLUTION (MHB-99-15): Be it resolved that the Mental Health Board of San Francisco strongly recommends that the City and County of San Francisco officially endorse SB 468 (Polanco) with the following condition: that no amendment be made to require copayment when an involuntary commitment is made. (Passed)**
>
> **RESOLUTION (MHB-99-16): Be it resolved that the Mental Health Board of San Francisco endorses the 9th annual Human Rights Vigil to be held on September 25, 1999, in Golden Gate Park.**

Ms. Leib reported as follows: The Annual Report is finished. This is a comprehensive statement of our MHB position on the budget and the state of the Mental Health System. When it came down to it, we made recommendations in only three areas: the budget, homelessness, and incarceration of the mentally ill. The reason for this is that without funding all other questions are moot. And if 30-40% of the homeless are mentally ill, and if 30-40% of the people in jail are dealing with mental illness, we're talking about an awful lot of people. I'm dismayed at the level of discussion about the budget and how it is a repetition of past years. I'm dismayed at the insistence on politicizing an issue that is not political.

Mr. Villalba: I'd like to thank you for all your hard work on the Annual Report. (Applause.)

Ms. Leib: It was hard work, but I like hard work. The Search Committee has conducted quite a few interviews. It's encouraging to see so many good people out there doing good work. We hope to have a new Executive Director by mid May. Rich has been doing great work. He's done a wonderful job in a difficult situation.

Program and Services Committee

> **RESOLUTION (MHB-99-17): Be it resolved that the Mental Health Board of San Francisco strongly recommends that the City and County of San Francisco officially endorse AB 34 (Steinberg) with the following conditions:**

1. That the original intent and spirit of the bill be embodied in the final version;
2. That an adequate level of funding per person be provided so that the program will not be set up for failure, but will have a fair chance to prove itself;
3. That the mode of treatment not be prescribed by the bill; and
4. That the funding for the bill come from the State share not the County share of the proposed funding source.

Children's Committee
Mr. Villalba: We had a meeting with Dr. Pat Anderson of the San Francisco Unified School District. She is in charge of restructuring Special Education among many other things. We had a very productive discussion and she agreed to attend the meetings of the Steering Committee of the Children's System of Care. It was great teamwork on the part of the Committee and Sai-Ling, Esperanza and Theresa from CMHS.

Mr. Snowdon: Sai-Ling Chan-Sew, Director of Children's Services has been doing a wonderful job of organizing a host of agencies and departments to coordinate their services for children and teens. Ms. Leib: Sai-Ling is a City Treasure! Mr. Snowdon: She has developed a great working relationship with Department of Human Services and Juvenile Probation, but Special Education was the missing piece. This new relationship with Dr. Anderson is the best news in years in terms of the connection between CMHS and Special Education. The Children's Committee put a lot of time into deciding the key issues to bring to the meeting, and worked beautifully as a team. In the midst of all the bad news this is definitely some good news to celebrate.

Committee on a Cultural Competency and Special Populations
Mr. Villalba: We thought though where we need to focus on homelessness. The issue taken as a whole is overwhelming, so were are focusing on the homeless population in relation to mental health services.

April Martin Chartrand
I spoke at the Health Commission about the pharmacy problems at San Francisco General Hospital. I was really nervous, because this issue is so important. Usually I'm not nervous at all. I made two key points that a) The SFGH Pharmacy lines are out of control, and b) this is contributing to medication noncompliance. Then I added 8 additional points about the impact of the problem: 1) wasted provider time, program productivity, 2) wasted prescriptions, 3) increased cost and utilization of crisis/hospital services, 4) client/provider frustrations, 5) risk of negative outcomes of care, 6) decreased client functioning/ability to care for self, 7) increased risk of social/legal problems, increased risk of involuntary treatment.

I then gave them solutions: 1) to speak to providers and to talk to people like me to find out what's really going on; 2) be brave enough to solve problems in an expeditious manner; and 3) listen to workable solutions.

Then I said that I was a different kind of person, so I was going to give them a poem as part of my testimony:

WAITING
When one is waiting in
the General's Pharmacy line,
it is easy
to lose your mind, oh me, oh my, oh why,

Healing can't come
in time
if your meds are behind the blinds

Bodies are dropping, minds are a-wasting
can this crisis be saved in time?
To see the forces that blind
the revelations of your mind.

Advocacy can be cool if you're in the right place at the right time and have the right attitude. The Commissioners were really listening to me. They were taking notes on what I was saying. That made me nervous.

Ms. Ruffin: I was at the hearing and I thought you were extremely effective and your nervousness did not show. The case examples you used were particularly poignant.

Dr. Moses: I want to commend April for all the speaking she's been doing. She's an expert. She's sending the message in a very diplomatic way.

Ms. Ruffin: I would like to let you know that CMHS does not rely on SFGH for pharmacy services. We have a contract with St. Mary's for indigent people and Medi-Cal recipients both. People can go to any pharmacy, then the charge is paid by St. Mary's Also people can go to our clinics. Mr. Villalba: Who uses the SFGH pharmacy, then? Ms. Ruffin: Primarily it's for indigent medical care. People with Medi-Cal can go other places. Mr. Agar: At the Glide Clinic we usually we send people who haven't the means to pay or need to work out a payment plan to SFGH.

Consumer/Family Member Task Force

Mr. Leoni: Mike Wise has been taking minutes and doing very well. He was also elected as a member of the Executive Committee. We've started our Policy Roundtables to prepare for future policy discussions. At our next meeting we'll be focusing on housing.

CMHS Leadership Work Group

In response to a question, Ms. Ruffin explained the Work Group as follows: This is made up of my Executive Staff Maria from the Mental Health Board, consumer and provider representation, and someone from the Department of Psychiatry at SFGH. This group was originally convened by my predecessor to help oversee the mental health managed care planning and implementation.

We're currently working on a grant proposal to the California Endowment. We originally prepared a proposal to support the Single Standard of Care. But the Endowment won't fund direct services. However, they said they would accept a proposal for a planning grant.

DPH Joint Advisory Committee

Mr. Snowdon: This is a relatively new Committee made up of representatives from DPH and all the advisory boards that are connected with DPH. The reason for starting it was to make sure there was no duplication of efforts, to develop joint projects between different sections of DPH, and possibly to do joint advocacy.

CMHS Committee on Culturally Competent Systems of Care

Ms. Chartrand: San Francisco is pretty much #1 in compliance in the State. I want to thank Tina Yee's office for being so vigilant.

The Cultural Competence Mental Health Summit VII will take place at the Oakland Convention Center, November 30-December 1, 1999.

We also discussed services for refugees from the conflict in Serbia.

VI. PUBLIC COMMENT

Mr. Kalman: Now is the time to ask the Mayor and the Board of Supervisors to put at least 5 people on the Police Department's Psychiatric Team and to have the Team staffed 365 days a year, 24 hours a day.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:02 p.m.

DPH

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MEETING OF THE FULL BOARD

Wednesday, May 12, 1999
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A A. Approval of April Minutes B. Approval of Leaves of Absence for May	5 minutes
III. PRESENTATION: JAIL PSYCHIATRIC SERVICES Marcus Hartsfield, Manager Jail Aftercare & Discharge Planning	45 minutes
IV. DIRECTOR'S REPORT	30 minutes
SHORT BREAK	5 minutes
V. COMMITTEE REPORTS • Executive Committee, Chair's Report • Children's Committee Attachment B: Legislation regarding children's services SB 487, AB 278, AB 575, AB 434, and SB 802 • Cultural Competency/Special Populations Attachment C: Declaration of Housing Emergency • Program and Services • Consumer/Family Member Task Force • SFGH CAB • CMHS Committees, MHB Representative Reports	20 minutes
VI. PUBLIC COMMENT PERIOD	10 minutes
VII. ADJOURNMENT	

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UNADOPTED MINUTES
Wednesday, May 12, 1999, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D.; (Acting Chair); Tim Agar; Jim Beauford, Ph.D.; Supervisor Sue Bierman represented by Millicent Bogert; April Martin Chartrand; Renee Deger; Darwin Dias; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Chester Villalba; Barbara E. Williams.

BOARD MEMBERS ON LEAVE: Maria Leib; Brian Peagler; Gloria Samayoa; Sylvia Shue, Ed.D.; Lora Traveler, M.A.

OTHERS PRESENT: Jo Ruffin (CMHS); Mike Wise (Consumer/Family Member Task Force); Emeric Kalman (Family Member); Helynna Brooke; Rich Snowdon (MHB).

PRESENTER: Marcus Hartsfield, Manager, Jail Aftercare & Discharge Planning

I. CALL TO ORDER/INTRODUCTIONS
The meeting was called to order by Peggy Gilleran, Acting Chair, at 6:37 p.m. She made the following remarks: This is a special night, because we have with us our brand new Executive Director for the Mental Health Board, Helynna Brooke. We're very proud and happy to have her as our new Executive Director.

Ms. Brooke: I'm excited about this position and the opportunity. I feel very honored to be selected. I've been involved in different aspects of the mental health field, mainly in the area of homelessness. From 1993 to 1997, I coordinated the Cecil Williams Glide Community House project, which will provide housing for people who come from a background of homelessness, substance abuse problems, HIV positive, or dysfunctional families. I'm currently a member of the Board of Directors of Glide Community Housing. I also worked for a number years with handicapped infants, such as those with Down's syndrome.

I bring a lot of passion and excitement to this position. I'm a hard worker, and I love networking. I find people fascinating. I like working with volunteers and this Board is made up of all volunteers. I like working with a wide range of people, who are passionate and committed.

II. CONSENT CALENDAR

RESOLUTION (MHB-99-18): Be it resolved that the minutes of the Mental Health Board meeting of April 14, 1999, be approved as submitted. (Passed)

RESOLUTION (MHB-99-19): Be it resolved that the Mental Health Board grant leaves of absence for the May 12, 1999, meeting to: Maria Leib, Brian Peagler, Gloria Samayoa, Sylvia Shue, and Lora Traveler. (Passed)

III. PRESENTATION: JAIL PSYCHIATRIC SERVICES

Mr. Hartsield made the following presentation: Jo Robinson, the Director of Jail Psychiatric Services, is sorry she couldn't be here tonight. I'm the Manager of Jail Aftercare and Discharge Planning. These are two components of Jail Psychiatric Services which is a program of the Haight Ashbury Clinic.

On the average the San Francisco Jail has 2,300 inmates on any given day. Seven percent of those, or 161 inmates, have serious mental illness. About half of them are clients of Community Mental Health Services.

Jail Psychiatric Services was founded in 1975. It is accredited by the California Medical Association. Jail Health Services holds our contract. They do the physical health part of the services and we do the psychiatric part. We have 52 full time staff, including a variety of mental health professionals.

There are several areas in the jail where mentally ill offenders are placed. These areas are monitored more closely than other areas. A new inmate is seen by a clinician within 24 hours of the arrest. If the person is 5150ed, then they are taken to the jail psych ward, Ward 7L at San Francisco General Hospital.

Jail Psychiatric Services saw 5,000 inmates last year and had 41,000 client contacts. We had 655 inmates who were 5150ed last year, and 152 in the first quarter of this year.

Jail Aftercare works with the courts and the Probation Department to make referrals to Community Mental Health Services to do post-release planning. Most of our time is spent in the courts and working with Probation doing advocacy for our clients who meet the mental health criteria. We follow them up to 6 months after their release from jail to support them in their transition.

We have a fund for emergency housing, and there are 3 case managers at CityWide Case Management who specialize in our population. We have been able to bring about a 70% reduction in the recidivism rate among our clients by using intensive case management. We've also seen that where there are re-offenses, the crimes are less severe and the jail stays are shorter.

You couldn't get a more complicated individual than the people we work with. They have a long history of incarceration and a long history of hospitalization. And you couldn't get heavier layers of bureaucracy. Some of our clients are difficult to place in programs. In the case of registered sex offenders, we can't place them, so we work with them on an outpatient basis.

For our clients, there is an endless cycle of involvement with the criminal justice system. They get on probation, then they don't fulfill the requirements or they are picked up for something else, and their probation is extended and this results in endless probation.

In the case of the misdemeanants, they are in jail for such a short time that we don't have time to really connect with them. We do complete an evaluation and the judge can order them into a program. For about every 10 ordered into a program, one actually goes into it.

What works well in our system is Citywide's intensive case management. They communicate with the clinical programs and supported housing. The CMHS Bed Committee is very committed to mainstreaming forensic clients and not discriminating against them. Baker and Progress work very well with our clients.

We are able to do temporary conservatorship in jail and then make it long term after the client gets out of jail. We do 5-6 conservator ships a year.

San Francisco did not get the State Department of Corrections grant that the Sheriff's Department applied for. But in the process of preparing the grant, we came up with a very good plan and we'll try to implement parts of that plan.

The Police Department's Psychiatric Liaison Unit is very understaffed. We see so many people arrested for quality of life crimes, who should be 5150ed. It's such a waste of police resources for the police to have to get involved in these cases, and its a crime for these people to be arrested and put in jail when that's not at all what they need. We need training for the police so they will be able to divert people to the hospital.

With regard to conservatorships, when an inmate is placed in Napa State Hospital, the Hospital should start the conservatorship process well before the release date. What happens now is that someone will spend 3 years in the Hospital and then will be returned to the jail and then sometimes will be released in 1 week, which doesn't allow enough time to set up conservatorship. We also need more probation officers to work with these clients.

There are a few programs that are hold outs. We feel that any community treatment agency should make provisions for our clients.

Mr. Villalba: What counties got funding under the State Department of Corrections grant? What was different in those proposals from what San Francisco submitted?

Mr. Hartsfield: The appointees on the Board were hold overs from the prior administration and it was mostly Republican counties that got the money. It seems that politics played a big part in the decision. Also some counties were so far behind San Francisco and the need for help was urgent. For example, Modoc County holds their 5150's in jail, because in the winter they can't get them over the mountains to the hospital. Also, it was partly our own fault, in that we asked for $7 million, which was too much money and we had too high a per person cost. Also the Board thought the evaluation component we proposed was too expensive.

Dr. Beauford: What's the ethnic breakdown in the jail and what's the percentage of African Americans. Mr. Hartsfield: African Americans are over-represented. I would guess they are 45% of the clients in Aftercare, and this reflects the general jail population.

Mr. Wise: What's the process when someone's arrested? Mr. Hartsfield: Police officers are currently making the call and all too often they take the person to jail. People are then screened on the way into the jail. They are triaged twice by jail health staff. If there is obvious mental illness, then they go directly to the psych section. Some inmates refer themselves to the psych section, and sometimes inmates refer other inmates to that section.

Ms. Deger: What about the complaints of the police, that they take someone to the hospital, and the person is released very quickly, sometimes in a couple of hours. Mr. Hartsfield: If a person is taken to jail, he'll get a longer period of treatment in jail as opposed to what he'd receive in the hospital. Ms. Deger: What can we say to the police about this situation? Mr. Hartsfield: In the long term, the person is in more trouble when they get taken to jail. They get better long term care, but it's still jail with all the legal issues.

Mr. Villalba: It sounds like a mess. Are there criminal justice systems in other cities which doing things well? Also, there are a lot of questions about whether treatment for sexual offenders is effective. In Florida they have a very effective program. Mr. Hartsfield: Birmingham and Austin are apparently doing well. In King's County there is a specialty court that is working well. In San Francisco the District Attorney's office is reluctant to do a specialty court for mental health. It's attractive to us, but the attorneys don't like it. They want to get their clients out of jail.

Mr. Hartsfield: Ninety-nine percent of our clients are dually diagnosed. When assessing people, we try to assign a percentage to how much of their problems are from substance abuse and how much are from mental illness, so we can send them to the appropriate programs. Many people in our psych units have drug charges.

Ms. Gilleran: Do you have any knowledge of what happens at the time of the arrest? Are people read their rights. Consumers are not always able to understand their rights?

What about the Miranda process? Mr. Hartsfield: Many of our clients probably don't understand it at the time of the arrest. Later after treatment, they might.

Mr. Shipley: Is there any provision for hiring more peer counselors to work in Jail Psych? I think the consumer who's had the experience of being in the jail has a lot to offer mental health clients who are in the jails and don't understand what's going on. Mr. Hartsfield: In the past we saw it as very successful and useful. We saw clients open up and respond in ways they wouldn't with us. We've had three peer counselors. The first situation was very bad. The second peer counselor got arrested. So we're a little gun shy right now. Maybe it doesn't work well in jail, but works well in community clinics.

Mr. Kalman: Is there any program trying to re-unite clients with their families? Mr. Hartsfield: Aftercare does try to work with families. We are working with the Sheriff's Department to start family therapy. The Service League does family work. But so many clients don't have families in the picture. Mr. Kalman: Do you provide art therapy? Mr. Hartsfield: Yes, we have one art therapist. This is one area in which we see the most shut down, isolative clients really come out.

Mr. Wise asked about medication. Mr. Hartsfield: If someone comes in under the influence of substances, there is a two week period without medications so we can get a clear picture of how much of the problem is mental illness and how much is the substance abuse. Some people become quite clear when they are off the drugs. If people need medications we then get them on the medication that works best.

Mr. Agar: What's the scenario for a typical client and who are the people you might routinely see working on a case. Mr. Hartsfield: The person is arrested and brought in by the police. They are then turned over to the Sheriff's Department, and are arraigned in 24 hours. So the judge, the District Attorney, and the client's lawyer are all involved. Then Jail Psych Services and Jail Medical Services come into the picture. There is also the Forensic AIDS Project, which has testing and counseling services. The Probation Office and medical social workers also are involved. Dr. Moses: There is also the Jail Ministry. Mr. Hartsfield: Yes, services are available as is one-to-one spiritual counseling.

IV. DIRECTOR'S REPORT

Ms. Ruffin reported as follows: I will be having hip replacement surgery on May 25th and will be gone for 2-3 months. During that time Collins Munns will be in charge of CMHS. Collins and Nancy Presson will work with the management. Nancy will assume operational duties, and Collins will be responsible for services and overall direction.

The Supplemental Budget Request was approved for $750,000 for pharmacy services. However the Mayor's office was opposed to adding the outreach and treatment component. Their concern was around the deficit, not the program itself. Since the vote, however, I have heard that something has been worked out, so there is likely to be outreach for the indigent population in the budget for next year.

The Board of Corrections grant through the Sheriff's Department was not funded. However, the same Board did provide $1 million of funding for Juvenile Justice.

Anytime there's disaster, CMHS provides disaster mental health services (under FEMA). We have tried to expand these services to include the hotel fires—about 10 have occurred since the beginning of the year. About 400 people have been dislocated. We will be hosting a statewide disaster mental health conference and are proud of this accomplishment. Linda Wang is in charge of disaster services for CMHS.

Jail Psych is a program of Haight Ashbury Clinic, with a contract with the Department of Public health. CMHS works very closely with Jail Psych, even though it's under the Community Health Network and we're under Population Health and Prevention. If clients stay too long in jail, they lose their Medi-Cal and SSI, so when they come back out, they have no coverage. We'll follow up to make sure people don't lose case management services, even if they've lost their Medi-Cal.

Dr. Moses: With regard to the peer counselors, even though two of the first ones didn't work out, there is a great need for peer counselors. They can be very effective. Please urge Jail Psych to continue the peer counselor program.

Ms. Williams: A lot of people won't trust the staff, but they will trust a peer who's been through the system.

Ms. Chartrand: I was dismayed, too, about the peer counselors. Other positions have staff who don't work out, either, and those positions don't get cut. Perhaps there's something wrong with how they're training and screening people. Maybe they need more support and mentorship for peer counselors. Mr. Shipley: The staff needs to be trained in working with peer counselors. It might behoove them to consider family members for peer counseling positions, too.

Ms. Ruffin: It occurs to me with all of your comments, you may want to make a recommendation to Jail Psych about peer counselors. We've had good experiences in CMHS working with peer counselors.

Ms. Deger: The hotel fires have caused the loss of 400 housing units. Is it just a matter of time to rebuild those hotels? Or will owners take the opportunity to turn them into tourist hotels.

Ms. Ruffin: It's a mixed picture. Some will be reopened. Some are so damaged they can't be saved. Marc Trotz of the Department of Public Health is following the issue closely.

Ms. Ruffin: Thank you for all the help you've given me since I've taken over as Director of CMHS. This job is not possible without a lot of help. I'm very proud of you. I'm taking a longer leave than I would otherwise take, and it makes me think about the people who matter to me.

V. MHB COMMITTEE REPORTS

Executive Committee

Our Chair, Maria Leib, our long-term partner, has decided this is the time for her to leave. There will be a gathering later to say good-bye to her and thank her.

Nominating Committee

Mr. Villalba: The Committee has met and is nominating Peggy Gilleran for the office of Chair and Jim Beauford for the office of Vice Chair. Toye will continue as Secretary. We are submitting the names tonight and will vote next month.

Children's Committee

RESOLUTION (MHB-99-20): Be it resolved that the Mental Health Board of San Francisco strongly recommends that the City and County of San Francisco officially endorse the following bills before the California State Legislature:

SB 487 (Wright) to continue funding for children's mental health services.

AB 278 (Honda) to support foster families with childcare.

AB 575 (Aroner) to encourage "best practice" assessments of the whole child in the context of the whole family.

AB 434 (Aroner) to provide financial aid for education to former foster care youth. (Passed)

RESOLUTION (MHB 99-21): Be it resolved that the Mental Health Board of San Francisco strongly recommends that the City and County of San Francisco officially oppose SB 802 (Haynes) which proposes to re-write dependency proceedings and child welfare statutes. (Passed)

Committee on a Cultural Competency and Special Populations

RESOLUTION (MHB-99-22): DECLARING A HOUSING EMERGENCY IN SAN FRANCISCO

WHEREAS, the crisis in affordable housing in San Francisco has for many years had a severe and negative impact on the lives of clients of the mental health system, and

WHEREAS, this housing crisis makes it much more difficult for Community Mental Health Services to do timely and effective discharge planning, with delays being costly both in financial and human terms, and

WHEREAS, the loss of housing by an individual or family can trigger a mental health emergency and a subsequent need for mental health services, which otherwise would not have occurred, and

WHEREAS, this housing crisis is rapidly getting worse, and

WHEREAS, enacting effective solutions to this crisis would be beneficial to the overall health and future of San Francisco, and

WHEREAS, the Mental Health Board strongly endorses Health Commission Resolution 14-99, and commends the Health Commission for adopting this Resolution, now therefore, be it

RESOLVED that the Mental Health Board recommends in the strongest possible terms that the City and County of San Francisco declare a state of emergency with regard to housing in San Francisco, and particularly with regard to the negative consequences for health care, and, be it further

RESOLVED that the Mental Health Board recommends in the strongest possible terms that the City and County of San Francisco take all possible emergency measures to dramatically increase the stock of affordable housing in San Francisco, and, be it further

RESOLVED that the Mental Health Board recommends in the strongest possible terms that the City and County of San Francisco do everything in its power to discourage runaway housing speculation and encourage the stabilization of affordable housing prices. (Passed)

Program and Services Committee
Mr. Shipley: We opened up the discussion of the Lanterman, Petris, Short reform. We tabled the CAT survey. We discussed the questions we have for the presentation on the Mental Health Rehabilitation Facility.

Mr. Shipley then handed out the state manual on managed care and made the following remarks: April and I went the to training offered by the California Association of Local Mental Health Boards and Commissions. We were disappointed that only two people from our Board attended. There are very important things coming down from the State level that we need to be aware of in order to be effective advocates. Ms. Chartrand: We really need to attend such trainings or arrange for them to come to our Board to train us.

Mr. Villalaba: Maybe we need to have some kind of workshop in addition to the Retreat.

Community Advisory Board, SFGH Department of Psychiatry
Mr. Shipley: We had a presentation by Dr. Francis Lu on Spirituality and Psychiatry.

Consumer/Family Member Task Force
Mr. Wise: We continued the policy roundtable about important issues we'd like to take on. Our #1 issue is housing.

CMHS Quality Policy Committee
Mr. Shipley: We discussed our association with Napa State Hospital, which is being turned into a facility for sexual offenders. The canteen, church and other services are now behind the fence where the offenders are housed, which means other mental health clients can't get to them. We had a presentation by Jim Gilday on grievances.

Dr. Moses: We need to look at Board attendance. It's the same people who are not showing up. We're all busy. Perhaps the Chair should send a friendly letter to ask them what's happening.

VI. PUBLIC COMMENT

Mr. Adamek discussed the funding crisis at Spiritmenders and the reality that it may go out of business in the next two months. He asked for help in saving the organization. Mr. Villalba discussed the consultations he's done with Spiritmenders and Ms. Ruffin said that she would ask Dr. Tina Yee to meet with representatives from Spiritmenders to see if CMHS could help in any way.

Ms. Deger announced that Brian Peagler, an officer with the San Francisco Police Department and a member of the Mental Health Board was commended on Monday April 26th by the Board of Supervisors for his work in reducing gang activity.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 9:26 p.m.

DPH

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MEETING OF THE FULL BOARD

Wednesday, June 9, 1999
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A A. Approval of May Minutes B. Approval of Leaves of Absence for June	5 minutes
III. VISIT WITH SUPERVISOR LELAND YEE	45 minutes
IV. DIRECTOR'S REPORT	30 minutes
SHORT BREAK	5 minutes
V. COMMITTEE REPORTS •Executive Committee, Chair's Report Election for Chair and Vice Chair of the Board Attachment B: PATH Grant Review Attachment C: Pharmacy at San Francisco General Hospital •Children's Committee Attachment D: Proposal by Youth for Access to Health Care Coalition •Cultural Competency/Special Populations Attachment E: Statewide Supportive Housing Initiative •Program and Services •Consumer/Family Member Task Force •DPH Joint Advisory Council Attachment F: Work Plan for the Council	20 minutes
VI. PUBLIC COMMENT PERIOD	10 minutes
VII. ADJOURNMENT	

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MENTAL HEALTH BOARD OF SAN FRANCISCO

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

UNADOPTED MINUTES

Wednesday, June 9, 1999, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D. (Chair); Tim Agar; Jim Beauford, Ph.D.; April Martin Chartrand; Renee Deger; Darwin Dias; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Chester Villalba.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Brian Peagler; Gloria Samayoa; Sylvia Shue, Ed.D.; Lora Traveler, M.A.; Barbara E. Williams.

OTHERS PRESENT: Collins Munns (CMHS); Emeric Kalman (Family Member); Helynna Brooke; Rich Snowdon (MHB).

PRESENTER: Supervisor Leland Yee

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I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Chair, at 6:36 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-99-23): Be it resolved that the minutes of the Mental Health Board meeting of May 12, 1999, be approved as submitted. (Passed)

RESOLUTION (MHB-99-24): Be it resolved that the Mental Health Board grant leaves of absence for the June 9, 1999, meeting to: Brian Peagler, Gloria Samayoa, Sylvia Shue, Lora Traveler, and Barbara Williams. (Passed)

V. MHB COMMITTEE REPORTS

This agenda item was taken out of order pending the arrival of Supervisor Yee.

RESOLUTION (MHB-99-25): Be it resolved that the Mental Health Board meeting scheduled for August 11, 1999, be canceled. (Passed)

III. VISIT WITH SUPERVISOR LELAND YEE

Supervisor Yee: We are in a rather difficult time in San Francisco. As Chair of the Finance Committee of the Board of Supervisors. It's difficult when we don't have enough money, but it's difficult, too, when we have a lot of money, because there are still so many needs all in need of funding. I say we're in a difficult time, because there are problems out there that the board of Supervisors can't solve, that DPH and CMHS think they can solve, but probably can't. It will take the work of people like you to make the difference.

San Francisco prides itself on meeting the needs of its people. I have two colleagues on the Finance Committee who are very willing to meet these needs. But we are currently not getting the kind of federal and state reimbursements we've gotten in the past, so to keep the same level of services we have to use General Fund dollars and that may mean shifting dollars from something else.

I'd like to challenge you to begin thinking about the shortfall from the federal and state levels, and to the extent you can help contribute to solving the problem for the whole Department of Public Health, that will help mental health services, too. Also, please look at how we can restructure mental health from the bottom up. The other two members of the Finance Committee are very supportive of your concerns. The question now, given the dollars we have, is: Do you deliver services as you've always done it, or do you change that? Work with the administration to figure this out and then move into the political arena.

Next year, I don't want to be Chair of the Finance Committee. I want to spend some of that money instead of balancing the books.

An issue which is dear to me is children's services. I am interested in looking at how we might co-locate services in the schools. If that means increasing the budget for children's mental health, I'm prepared to do that and to hold the School District's feet to the fire.

Supervisor Katz has a broader proposal to put clinics in the schools, but only for the high schools. But the middle school years are so important. How do you reshape mental health services at the school? What's the role of teachers and therapists? I've already asked Mitch Katz to begin discussion on this and you need to be in this discussion as well.

This is not a case where the plan will take City dollars. The School District can bill for services. That's something I set up when I was on the School Board.

I used to be on the staff at the Chinatown Child Development Center. We had a program for families that involved child care being given by mental health professionals, so they could screen for problems. We were able to provide parenting classes and support. I am looking at providing that model throughout the City.

I focus on children, because children are so vulnerable, and have gotten pushed aside. This is a chance to give them a better life.

Mr. Villalba: I appreciate the model you are talking about. I know of a collaborative effort between San Francisco State University and the Family Service Agency, where a two year pilot was done, placing mental health consultants in the schools. They provided 1:1 intensive consultation with the teachers on how to work with kids who had behavioral or mental health problems. It was a very successful model.

Supervisor Yee: What currently exists in San Francisco is a collaborative between the School District and CMHS. Consultants provide support to SED classrooms.

So much of the work with children should have been done earlier. I want to see early diagnostic work and linking children up with services early on.

Dr. Moses: I want to commend you for being sympathetic to mental health issues. This Board advocates for services, because if we don't provide services then it will cost more to the City and County later. I urge you to do whatever you can to minimize the shortfall to mental health. I'd also like to know what advice you could give us on how we can be more effective.

Supervisor Yee: What Dr. Moses is alluding to is a proposal by the Mayor to add 1,000 employees to the City's payroll. I question if we need all that. I wonder if we couldn't utilize the staff we have more efficiently. In business, if the need for the product goes down, there is a corresponding drop of staffing. But City services don't work that way. With regard to the Police Department, maybe we don't need cops where crime has dropped. Perhaps we can redeploy officers. Maybe we don't need 200 additional officers, and then we could use that money for other needs.

When we have a little breathing room, that's the time to study the whole budget and see where we can better deploy our resources. Government tends to be top down and I like to operate government from the bottom up. I encourage you to be involved.

Mr. Agar: I come from a strong billing background, and am concerned about the federal and state cutbacks. I'm curious about our recovery of money for San Francisco General Hospital and clinics that are capable of billing. How well are we doing on claims? In Hawaii, millions and millions of dollars were lost because claims were not followed up.

Supervisor Yee: The reimbursement rates and inability to collect on all clients we serve is an important issue. This is a major problem in DPH. Because of the generosity of my colleagues on the Board, we've given another $25 million to DPH, but unfortunately those dollars are already spent on high-end services at San Francisco General Hospital and Laguna Honda.

If you don't participate, more resources are going to be sapped away from mental health needs to physical health needs. We have to press hard on Washington, D.C., to increase reimbursements. I'm committed to Laguna Honda, but it's an institution that is a throw back to another time. So there is a shortfall and the more we fill the shortfall, the more we have a structural problem in the budget. Many individuals have no insurance, but we need to pursue billing whenever possible. Ambulance services are not collecting all they could.

Mr. Shipley: Do you have any suggestions on how we can advocate for better management and control over shortfalls? The Mental Health Board is mandated by the State to be the public arm of mental health services. But we are limited in what we can lobby for at the state and national levels.

Supervisor Yee: My suggestion is that the leadership of your Board set up meetings with Barbara Boxer and Dianne Feinstein and let them know how dire this situation is. There is no way I can find $25 million for DPH again next year. And every time we fill the shortfalls, we lose opportunities to do other things. I'd also recommend setting up meetings with John Burton, Kevin Shelley, and Carole Migden. San Francisco is in a different situation than other jurisdictions which shut down services which are not being reimbursed, because San Francisco is more compassionate.

Dr. Beauford: When you are talking about re-shaping mental health services, help us to get an idea of where to focus, such as inpatient or outpatient. I heard you focusing on prevention and children's services. General re-shaping sounds almost impossible.

Supervisor Yee: One thing Community Mental Health Services does well and should be proud of, is that we have worked hard on the services for the severally mentally ill. One of the best known programs is the Family Mosaic Project, which is a leader in intensive case management. We do extremely well in this area. What we don't do well with is preventing youngsters from getting to the point of crisis in the first place. But this becomes a big issue because we are talking about so many children. And who's responsible for it—CMHS, DHS, the School District—goes into never never land. What model should we be following? If we could figure out a new way to do prevention, we'd be light years ahead. We could really put ourselves out of business in terms of the high-end services. It's an exciting thing to think about because people have not done this.

We all have some understanding of the power of prevention. We have not figured out a way to institutionalize it as part of our own system. But we know that primary prevention programs in partnership with the schools have been effective.

Dr. Beauford: I am the Chair of the MHB Children's Committee. We have begun to breach some of the never never land working with Special Education and SFUSD. We met with Pat Anderson to formally offer our assistance. Is there any way to be in a closer working relationship with your office?

Supervisor Yee: You can call Michele Olson in my office. After the shooting in Colorado, we pulled together people to talk about how San Francisco could respond. Graeme Hanson is very into school based mental health services. Unfortunately there is not enough time to establish that group and impact the budget this year. So I'm having conversations with individuals, and am setting aside some money in this budget. We want to develop a rough sketch for the proposed services and work out the details later. Please feel free to connect with Michelle on this.

Mr. Villalba: In terms of restructuring mental health services, and our role in monitoring, we want to look at staffing patterns and production to make sure we're getting the most out of our staff. The MHB's relationship with CMHS administration is the best I've ever experienced with a public department. Do you have specific ideas on monitoring?

Supervisor Yee: The way I look at this Board is that you are the voice of the citizens on mental health. You are appointed by the Board of Supervisors. I encourage you to look at your charge broadly, look at the whole of San Francisco. What works and what doesn't? I know with the mental health bureaucracy, if you start to talk about restructuring the bureaucracy starts to tremble.

We have to ask, What is the best way and most efficient way of delivering services. It's important in this flush time to sit back and evaluate services—apart from rules and regulations—in a sense to dream, and then came back to us with ideas and recommendations.

It absolutely pains me to see adolescent young people who don't feel they have a stake in life. How did we miss all of them? Is there anything we could do now to salvage their lives?

Ms. Gilleran: Dr. Yee, it's very affirming what you see our role should be, that you see it as very broad, and that we are to look critically at the mental health system.

Supervisor Yee: I believe we should not create bodies that will rubber stamp things or simply go through the motions. It's always a bit more cumbersome for us in government to have more worries, but it's important to have your input and recommendations. We're much richer for it.

Dr. Beauford: It's wonderful to hear your comments, specifically on young children. In a city as grand as San Francisco, there are no inpatient services for young children. I hope you sustain this as a concern and that it rubs off on your colleagues.

Ms. Gilleran: Thank you so much for coming this evening.

IV. DIRECTOR'S REPORT

Highlights of the report by Collins Munns include the following: Jo Ruffin sends her greetings and says to tell you that she misses you.

With regard to the City budget, the Mayor included a 2% COLA which is very important to contract services, where the majority of our dollars are. Roughly 3/4 of our services are contracted. Without the COLA, we'd possibly face a reduction of services. The services cost more every year, so if there is no increase, the services get reduced.

The DPH hiring freeze has been lifted effective July 1st. The freeze has had a very detrimental effect on mental health services.

DPH has formed the Bridge Committee which is like the CMHS Bed Committee. It will control treatment beds, and will focus on how to place hard-to-place individuals. When placements cannot be found these individuals are staying at the high-end institutions which cost large amounts of money. There are people who are in these high-end services who are ready for discharge, but who can't be discharged because there is nowhere to send them.

V. MHB COMMITTEE REPORTS

Executive Committee

Ms. Gilleran: During the last few months, in the role of Acting Chair, I have been thankful for the work and being of Rich Snowdon. I want to thank him for everything he's done, despite his grief at losing Mary Sue who he worked so closely with, and all the extra work during these months.

An election for Chair of the Mental Health Board was held to replace Maria Leib whose term has expired and who has left the Board. Peggy Gilleran was elected Chair unanimously.

An election for Vice Chair of the Mental Health Board was held to replace Peggy Gilleran who was elected Chair. Jim E. Beauford was elected Vice Chair unanimously.

Ms. Gilleran: Our MHB meetings with the Supervisors are going beautifully and we're learning a lot. I want to commend Helynna. This woman has lived up to everything on her résumé and in her interviews. I want to thank the Search Committee for your work. We've got a winner!

RESOLUTION (MHB-99-26): REVIEW OF PATH GRANT RENEWAL

WHEREAS, the Projects for Assistance in Transition from Homelessness (PATH) Grant meets a critical need and has been well managed and administered in the City and County of San Francisco, now, therefore, be it

RESOLVED, that the Mental Health Board of San Francisco prepare a letter to be included with the PATH grant submission stating that the Board has reviewed the grant, and additionally stating that the Board gives its full support and endorsement to the grant. (Passed)

RESOLUTION (MHB-99-27)
SUPPORT FOR FULL FUNDING FOR THE PHARMACY AT SAN FRANCISCO GENERAL HOSPITAL

WHEREAS, the recent cut in funding for the Pharmacy at San Francisco General Hospital and the closing of the satellite Pharmacy has proven to be disastrous to the indigent, uninsured, and under-insured population of San Francisco, and

WHEREAS, the unconscionably long waits in the pharmacy line has caused people to suffer undue stress and exhaustion, often in direct contradiction to the treatment ordered for them by their doctors, and

WHEREAS, the difficulties of getting medications has led to medication noncompliance for far too many people, and

WHEREAS, long delays in getting medications has in some cases proven to be life-threatening, and

WHEREAS, the working conditions for the staff of the pharmacy—facing the same level of demand for service with fewer resources and facing the frustration and anger of distraught clients—are hardly tolerable and are not good for the mental or physical health of those staff, now, therefore, be it

RESOLVED, that the Mental Health Board of San Francisco urge the Mayor, the Board of Supervisors, and the Health Commission to immediately commit the necessary share of the City's current budget surplus to restoring full scale pharmacy services at San Francisco General Hospital, and to making sure that unnecessary delays, frustration, and noncompliance are eliminated, and to ensure that the working conditions for pharmacy staff are made tolerable. (Passed)

Children's Committee

RESOLUTION (MHB-99-28)
PROPOSAL BY YOUTH FOR HEALTH CARE COALITION

WHEREAS, there is an urgent need for access to health care, including mental health services, for high school students in the City and County of San Francisco; and

WHEREAS, prevention and early intervention and treatment is cost effective, and

WHEREAS, the Youth for Health Care Coalition has worked intensively to study the problem of health care for high school students and has developed an excellent and comprehensive proposal, and

WHEREAS so much unnecessary illness and suffering would be prevented under this Proposal, now, therefore, be it

RESOLVED, that the Mental Health Board of San Francisco endorses the Proposal by the Youth for Health Care Coalition for School-Based Health Care and urges the Mayor, the Board of Supervisors, and the Department of Public Health to work closely with this organization in continuing to develop, fund, and carry out the Proposal, and, be it

FURTHER RESOLVED that the Mental Health Board urges that the following conditions be met under this Proposal:

1. That the San Francisco Unified School District not consider that the mental health clinicians funded through this program are a substitution for school counselors and that the School District continue and increase their counseling positions.

2. That the Health Department funding required for this high school Proposal not be shifted from other Departmental programs and priorities, but that the funding required come from the City's General Fund as new money for the Department of Public Health.

3. That the City's General Fund money not be used to pay for services for young people who already have coverage through Medi-Cal or private HMO's, and that sufficient support staff be provided under this Proposal so that appropriate billing can be done, thus allowing General Fund dollars to be targeted for students who have no other source of health and mental health coverage. (Passed)

Cultural Competency and Special Populations

RESOLUTION (MHB-99-29):
STATEWIDE SUPPORTIVE HOUSING INITIATIVE

WHEREAS, there is an urgent need for supportive housing in the City and County of San Francisco, for seniors, families, homeless people, and others who have very low or extremely low incomes—especially those with chronic health conditions, including mental illness or developmental disabilities, and

WHEREAS, Governor Wilson signed the Statewide Housing Initiative into law, and

WHEREAS, the Initiative has not been funded to date, now, therefore, be it

RESOLVED, that the Mental Health Board strongly encourages the City and County of San Francisco to officially endorse the Statewide Supportive Housing Initiative, and support funding it at the level of $10 million through the State Department of Mental Health budget. (Passed)

DPH Joint Advisory Council

Mr. Munns: The intention of this Council is to better coordinate the work of the key advisory bodies for the Department of Public Health. Last year there was almost a disaster when the Ryan White Care Council cut $800,000 of mental health funding. They had no real understanding of the impact of that decision. They thought they could send those 1,200 clients to CMHS and we'd just absorb them. This Joint Council is to help prevent such misunderstandings.

Ms. Gilleran: Chet Villalba is the representative to this Council.

Mickey Shipley was chosen as the alternate representative.

RESOLUTION (MHB-99-30): WORK PLAN FOR JOINT ADVISORY COUNCIL Be it resolved that the Mental Health Board gives its approval to the work plan for the Joint Advisory Council of the Department of Public Health as revised on April 2, 1999. (Passed)

VI. PUBLIC COMMENT

Mr. Kalman commented on the reduction of funding for community care in the City budget for fiscal year 1999/2000.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:30 p.m.

DPH

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MEETING OF THE FULL BOARD

Wednesday, July 14, 1999
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

AGENDA:

I. **CALL TO ORDER, INTRODUCTIONS**	5 minutes
II. **CONSENT CALENDAR** See Attachment A A. Approval of June Minutes B. Approval of Leaves of Absence for July	5 minutes
III. **PRESENTATION ON HOUSING** Marc Trotz, Director of Housing Development, Department of Public Health	60 minutes
IV. **DIRECTOR'S REPORT**	20 minutes
SHORT BREAK	5 minutes
V. **COMMITTEE REPORTS** • Executive Committee, Chair's Report Attachment B: SAMHSA Grant Review • Additional Committee reports as needed	15 minutes
VI. **PUBLIC COMMENT PERIOD**	10 minutes
VII. **ADJOURNMENT**	

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UNADOPTED MINUTES

Wednesday, July 14, 1999, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D. (Chair); Tim Agar; Millicent Bogert for Supervisor Sue Bierman; April Martin Chartrand; Darwin Dias; Gloria Samayoa; Mickey Shipley; Lora Traveler, M.A.; Chester Villalba; Barbara E. Williams.

BOARD MEMBERS ON LEAVE: Jim Beauford, Ph.D.; Renee Deger; Toye Moses, Ph.D., M.P.H.; Brian Peagler; Sylvia Shue, Ed.D.

OTHERS PRESENT: Collins Munns (CMHS); Araba Blankson (Glide Health Clinic); Mark Adamek (San Francisco Depressive and Manic Depressive Association; Spiritmenders); Gail Bufford (San Francisco Depressive and Manic Depressive Association); Mike Wise (Consumer/Family Member Task Force); Emeric Kalman (Family Member); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

PRESENTER: Marc Trotz, Director of Housing Development, Department of Public Health

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Chair, at 6:39 p.m. She announced that the Mental Health Board meeting has been moved to Room 537 on the 5th Floor at 1380 Howard Street, since Room 537 has better ventilation and better light.

II. CONSENT CALENDAR

This item was postponed until after the presentation.

III. PRESENTATION ON HOUSING

Ms. Gilleran introduced Mr. Trotz as follows: Marc Trotz is the Director of Housing Development for the Department of Public Health. His focus is on developing housing for specific populations such as: people who are currently homeless, people with disabilities, people with mental illness, and people with substance abuse issues. Prior to this position, Marc was with the Mayor's Office of Housing and from 1994-1995, he was the Homeless Coordinator for San Francisco. Marc has a thorough understanding of both local and national housing issues, especially as they relate to special populations.

Mr. Trotz made the following presentation: First I'll say a few things about my observations about housing, then I'd like to find out your concerns. The housing situation in the City is the worst in a long time, if not ever. I know you all know this. The idea that if we just had more money or more brain power we could figure out this crisis is just not true.

There is a less than 1% vacancy rate. Middle and upper income people are fighting to live in the Tenderloin. Lousy SRO's are going for $500 a week. Rooms without baths are going for $300 a week. That's just a backdrop. One of the contributing factors is that San Francisco is geographically limited. We have water on 3 sides. We have 300,000 and some housing units, and not a lot of new development. Only 10% of those 300,000 units have some sort of affordability restrictions. We are only marginally increasing the number of affordable units.

The Housing Authority has 30,000 applicants for their units. They hold a lottery to bring that number down to 1,000. People who are given the vouchers still can't find housing.

Affordable housing breaks out into two main tracks. First are the nonprofit developers who are trying to add new housing to the stock, but this is a long term process. The other track is private landlords. this is the track I'm more interested in, because it's more immediate. We are working with private landlords to open up housing stock through master leases, where we take over all the units in the building and manage them.

The handout shows a list of units in the pipeline through the Mayor's Office of Housing. A lot of these projects will house people with disabilities. But this is a very slow process and the new projects, while worthwhile, are a drop in the bucket compared to what's needed. It's important to know about these projects and be very assertive about getting your clients on the waiting lists for them.

The way these projects get in the pipeline is that organizations like Progress, Baker, and TNDC, respond to NOFA's from the Mayor's Office of Housing. NOFA stands for Notice of Funding Available.

Recently a NOFA came out that did not get a lot of good response. The first priority was housing for people with mental illness in need of services. The Mayor's Office did not get flooded with responses. We're not getting the project sponsors to come forward.

Mr. Villalba: What's your take on why that's so? Mr. Trotz: The three main groups, Conard, Baker, and Progress, have other things happening and perhaps did not feel they could handle it. Also development is very tough and contentious. There is not only the NIMBY response, but on the City's side of it, we don't always make it as easy as we need to. For example our DPH contracts for providing support services are done on a year by year basis, but the sponsors really need a 5-year commitment of funding.

We are also working with the private market to master lease whole buildings. We just did two hotels. We took crappy hotels and paid off the owners, then hired our own staff and are bringing in services. These hotels are the Windsor and Pacific Bay Inn. At the Windsor, DPH provides the services and the John Stewart Company provides the property management. At the Pacific Bay Inn, the Episcopal Community provides services, Baker Places provides clinical support, and Mercy Services is the property manager. We brought in 180 people to these sites, people who were extremely low income or homeless, and who have been revolving through our services.

I think there are going to be many options for more projects in private housing stock such as co-op apartments like the ones run by Conard House and Baker Places.

A big barrier to community-based housing is that the State of California is so behind on funding support services for the housing. It costs $215 a day to house someone at Laguna Honda, but only $30 a day to provide services in the community.

The New York New York Project provided hundreds of millions of state funding to community-based housing and services, and was so successful that New York New York 2 was funded. This is what San Francisco needs—significant money for community-based housing and services.

Carla Javits of the Corporation for Supportive Housing led an incredible effort this year to get similar housing funds in California. Last year state legislation set up the mechanism for such funds. This year advocates attempted to get $10 million for supported housing into the state budget, but that was cut to $1 million, which is an inconsequential amount compared to what needs to be done.

Mr. Villalba: How were the residents chosen for the new projects. Mr. Trotz: We're experimenting with something different. At the Pacific Bay Inn, the focus is on the homeless. We worked with selected network of referral agencies, including street outreach , shelters, and Citywide Case Management. We worked closely with the referral gate agencies so they would really understand who would be appropriate for this housing.

Ms. Brooke: Don't hotels have to follow fair housing laws? Mr. Trotz: HUD and other agencies don't have a problem with target referral gates as long as the system of choosing residents is fair within the target group. If we're funding housing for a specific group, it doesn't make sense then to throw the housing open to anyone.

Mr. Shipley: Why do SRO's hold back rooms instead of renting them all out? Mr. Trotz: I have learned a lot about SRO's. Some hold back rooms because they are thinking of doing something else with the hotel in a year or two and it's less trouble to make the change if the hotel is not full. It makes it easier to evict tenants. Or perhaps the hotel is renting tourist rooms and holding back some of the residential rooms.

Some owners have a cash flow problem, and the kind of offer we make about leasing a whole building creates a chance for them to get out of running the hotel and let us take over.

Ms. Traveler: Where does the master lease money come from? Mr. Trotz: It comes from the Department of Public Health. We were able to convince the Mayor to put a couple million dollars into the Windsor and the Pacific Bay Inn. We made the case with the Mayor that when you look at the costs of such housing it's not much more than the Mission Rock Shelter, which has essentially no services.

Ms. Traveler: What's Governor Davis doing? Mr. Trotz: Governor Davis blew it. There was more money for this new housing initiative, and he had a hand in cutting it from $10 million down to $1 million.

Ms. Traveler: What about funding for the immigrant population? Mr. Trotz: They don't have a special fund. When the family apartments at 201 Turk Street in the Tenderloin opened up the Russian Community was organized. There was nothing unfair about it, but they got more people on the list and did better getting people into the project.

Mr. Villalba: The Russian example is a good one. They have a constituency and do a lot of behind the scenes advocacy. I think they're smart. I think advocacy is what has to happen.

Mr. Shipley: Do you have any update on TIDHI? Mr. Trotz: TIDHI stands for Treasure Island Housing Development Initiative, which is a coalition of 14 organizations. Things are moving slowly. They have an agreement with the City to have access to 1100 units on the island. They've selected their first organizations (Swords to Plowshares and Haight Ashbury Free Clinic) and are starting to open units. Catholic Charities will be in the next wave. This is frustratingly slow work, but it's starting to pan out.

Mr. Villalba: Is there a master plan for the City for housing? Are there people working on it? Mr. Trotz: The main group focusing on housing strategy is CHAS, the Comprehensive Housing Affordability Strategy advisory committee, lead by Marcia Rosen of the Mayor's Office of Housing. It's advisory to the Mayor and includes City departments as well as community groups. It's where policy is set.

Mr. Villalba: How could we get access to the New York New York Project? Mr. Trotz: It's a deal between the City and the State of New York. The Corporation for Supportive Housing has all the information. Their national office is in New York and they have a local office in San Francisco. There are a lot fewer homeless people on the streets in New York now.

Mr. Wise: I'm a resident of a residential care home. I've become active over the years and attended meetings of residential care operators. They feel short changed. Hospitals get a lot more money for clients when they are hospitalized but don't provide a lot more care than the residential care operators provide. If you have the ear of the Mayor or Mitch Katz, could you let them know that the residential care operators are needing more support from City government. In over 20 years, we've lost half the homes and there is more demand for placements. There is no incentive to open new homes.

Mr. Kalman: We have in this city 20-30,000 illegal units, a black market of units. The Building Inspector is proposing to bring those units up to code. These are not wealthy homeowners who have these units. What is the legal position of the Mayor's office? In my opinion we should do nothing about this, otherwise we'll see 10,000 more people out of housing.

Mr. Trotz: This issue has come and gone for many years. I think nothing will happen, which is what you're recommending.

II. CONSENT CALENDAR

RESOLUTION (MHB-99-31): Be it resolved that the minutes of the Mental Health Board meeting of June 9, 1999, be approved as submitted. (Passed)

RESOLUTION (MHB-99-32): Be it resolved that the Mental Health Board grant leaves of absence for the July 14, 1999, meeting to: Jim Beauford, Rene Deger, Toye Moses, Brian Peagler, Sylvia Shue. (Passed)

IV. DIRECTOR'S REPORT

Mr. Munns reported for Jo Ruffin as follows: AB 34 is in some trouble in terms of funding. Assemblymember Steinberg focused his legislation on the homeless mentally ill and the mentally ill in the criminal justice system. It's not clear how it will play out over the next week or so. Governor Davis wants to fund pilot programs for a year. Others want competitive grants. But it looks like there won't be more than $10 million.

With regard to the Department of Corrections mentally ill offender grants, San Francisco and Los Angeles each were awarded $5 million for their proposals. Originally only 7 counties were funded. Then additional money was allocated to include San Francisco and Los Angeles. San Francisco's original proposal was for $7 million.

Jo Ruffin has indicated that she hopes to be back with you at your next meeting in September.

SEIU threatened a job action against the residential treatment programs, including Baker Places, Progress Foundation, and Conard House. A strike was voted on which would have started on July 12th. We've been working with the union and have been able to adjust some of the issues so a recommendation was made by the union committee to rescind the strike vote. Two hundred clients would have been displaced. It would have been a major disaster. It look like the settlement will go forward. We'll know the results by the end of the week.

The City budget is still in process. It's still not officially adopted. Some one-time funding is being added back into the budget. New Leaf, which has had to turn people away, got an additional $75,000. Supervisor Yee is really interested in a children's initiative, and in looking at primary prevention and systems changes—so people will not require our services and won't get into our system in the first place. We're following up on that. Very rarely do we get a chance to look at primary prevention.

The hiring freeze which was in place for 7 months has been lifted. There is a requirement in the Department of Public Health for increased salary savings, so some positions are not being filled. The projected average of salary savings is 5%. We're being asked to increase that to 8-9% savings. To do that involves some delayed hiring. So some hiring will be held off till October and some till January.

Mr. Wise: Is there any information on the progress of the Lanterman, Petris, Short reform? Mr. Munns: There's no update, except that this keeps on being a hot item. The California Mental Health Directors Association has been putting a lot of effort into dealing with this issue in a way that does not split the mental health community. It has the potential to do that. We've got a strong constituency for mental health and we don't want to see splitting happen. We can't afford that.

A possible future agenda item for the Board, perhaps for October, would be Children's Services. There have been a lot of new developments. Perhaps Sai-Ling Chan-Sew could come in and do a presentation.

V. MHB COMMITTEE REPORTS

Executive Committee

Ms. Gilleran called attention to the new MHB Snapshot which is a one-page summary of Board activities for the month prior to the Board meeting, saying: This is the creation of the ever creative and productive Rich Snowdon. It includes our three priorities to help us keep our focus.

Ms. Gilleran then thanked Helynna for the publicity provided for the Board through the photo and short article printed in the *San Francisco Independent*.

Ms. Brooke thanked Ms. Chartrand for making a connection for the Board with *Women in Business*. That publication is interested in doing an article.

Mr. Shipley distributed excerpts from the California Mental Health Master Plan, saying: I don't know how many of people on this Board have read the whole Master Plan. These excerpts are just the opening pages, but they really show part of what we are charged with, to make sure consumers get the most effective treatment in the least restrictive environment in their own community if possible.

Ms. Gilleran: Each year the Mental Health Board is asked to review the renewal of the grant from SAMHSA.

RESOLUTION (MHB-99-33)
Be it resolved that the Mental Health Board send a letter to Nancy Presson, Associate Director, Community Mental Health Services, stating that the Board has reviewed the CMHS renewal proposal for the 1999-2000 block grant from the Substance Abuse and Mental Health Services Administration, and that the Board gives its full approval and support to this grant. (Passed)

VI. PUBLIC COMMENT

Mr. Adamek thanked the Board for its support of Spiritmenders.

Mr. Villalba announced that a new CMHS committee has been formed to determine how the new $1.3 million of funding in the 1999/00 budget can be most effectively spent on programs. Mr. Munns noted that Spiritmenders will receive funding from CMHS in the 99/00 fiscal year.

Ms. Traveler thanked Ms. Gilleran for her work as the new Chair of the Board and Ms. Brooke for her work as the new Executive Director.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:19 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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ancelled

The Mental Health Board meeting scheduled for August 11, 1999, has been CANCELED

The next meeting of the Board will be Wednesday, September 8, 1999, in Room 537 at 1380 Howard Street.

An agenda for that meeting will be sent out at the beginning of September.

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MEETING OF THE FULL BOARD

Wednesday, September 8, 1999
1380 Howard, **Room 537**
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A A. Approval of July Minutes B. Approval of Leaves of Absence for September	5 minutes
III. PRESENTATION Collins Munns will present CMHS plans for coordinating mental health services with the criminal justice system.	45 minutes
IV. DIRECTOR'S REPORT	30 minutes
V. COMMITTEE REPORTS • Executive Commitee, Chair's Report • Additional Committee reports as needed	15 minutes
VI. PUBLIC COMMENT PERIOD	10 minutes
VII. ADJOURNMENT	

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SECURITY GUARD

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UNADOPTED MINUTES

Wednesday, September 8, 1999, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D. (Chair); Tim Agar; Jim Beauford, Ph.D.; April Martin Chartrand; Renee Deger; Darwin Dias; Mickey Shipley.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Toye Moses, Ph.D., M.P.H.; Brian Peagler; Gloria Samayoa; Chester Villalba.

BOARD MEMBER ABSENT: Lora Traveler; Barbara Williams.

OTHERS PRESENT: Collins Munns (CMHS); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Chair, at 6:47 p.m. She then made the following announcements: It's my sad duty to report that Sylvia Shue is resigning from the Mental Health Board for health reasons. She has been a most valuable member of the Board and we'll be thinking of her. We'll be sending her a certificate of appreciation for her Board service.

Brian Peagler will be returning to active Board service beginning in November.

II. CONSENT CALENDAR

RESOLUTION (MHB-99-34): **Be it resolved that the minutes of the Mental Health Board meeting of July 14, 1999, be approved as submitted. (Passed)**

RESOLUTION (MHB-99-35): **Be it resolved that the Mental Health Board grant leaves of absence for the September 8, 1999, meeting to: Toye Moses, Brian Peagler, Gloria Samayoa, Sylvia Shue, Chet Villalba. (Passed)**

III. PRESENTATION

Ms. Gilleran: We are privileged to have Collins here to talk about Community Mental Health Services (CMHS) plans for coordinating mental health services with the criminal justice system. It's important to see how CMHS sees the interface and what their perspectives are.

Mr. Munns: The area of criminal justice and how it interfaces with Mental Health Services and Substance Abuse Services is a very complex one. Today is sort of a progress report vs. a complete report. The situation as it is currently is almost impossible to coordinate effectively. For example, you have Forensic Services in the jail which is not related to CMHS. Jail Aftercare has no relationship with CMHS. The District Attorney's Office and the Sheriff's Department are responsible for the jail inmates. The State Department of Corrections is responsible for parolees and state prison inmates. There is the Superior Court. The Conditional Release Program is not related to anything else, not even the parole system and the State adult outpatient program.

This is a very, very fragmented system, if you want to call it a system. To try to pull the system together is a very big challenge.

In response to the awarding of the mentally ill offender grant to San Francisco, a plan has been developed that is somewhat different from the overall proposal. The plan describes all the agencies and entities involved in services for mentally ill offenders and ways to coordinate these services. The plan is more on the descriptive level.

Under Population Health & Prevention, of the Department of Public Health, there is a Criminal Justice Work Group. We are debating to what extent we want to rely on this plan.

How offenders get into the mental health system is complex. The may be referred. They may come through Psychiatric Emergency Services. People in the State hospital system are increasingly sent there through the forensic system. At Napa State Hospital, we now have only 40 mental health beds, the rest, about 200, are forensic beds for people who have committed serious crimes and who have mental disorders.

There are currently 199 persons from San Francisco with serious felony convictions who will be coming back here. Preparations for this transition are almost non-existent. It's unclear where the State's responsibility ends and the City's responsibility begins. It's a very complex picture. It's going to require a lot of time and perhaps reorganization to make things work.

With regard to the MIO grant, planning is the first step. The Executive Steering Committee includes most of the key players, except for the Conditional Release Program and the State Outpatient Program. Superior Court judge is part of the ESC, and this is really important. The system won't work without the Court involved and behind it. The Judge attended the ESC and was really helpful. He said sometimes he has to release someone who is incarcerated and just pray.

We did a SWOT analysis of the current system—strengths, weaknesses, opportunities, and threats. Some of our findings included:

Strengths

Good in the area of custody, especially with substance abuse issues, and other treatment issues like domestic violence.
Reasonable budget to work with.
Captive target population.
Good communication between Jail Health and the Sheriff's Department.
A progressive Sheriff's Department.
Good facilities.

Weaknesses

Lack of medical liaison with the Community Health Network of DPH to help inmates back into the community.
Lack of proper methadone treatment.
Lack of transition services.
Lack of substance abuse training for jail staff.
Need for cultural competence.
Lack of reimbursement for services.
Public attitude toward the incarcerated population—out of sight, out of mind.
Need more access to medical records and much better sharing of medical information.
Need for education of Superior Court judges on inmate issues.
Lack of long-term housing.

Opportunities

Jails are becoming identified as points of intervention.
We'll see people coming back out after this recent boom of incarceration. Release will dramatically increase in coming years. Legislators are seeing that something needs to be done.
MIO's are being recognized as underserved.
More acceptance for treatment on demand for substance abuse and even mental health.
De-institutionalization—people are seeing that institutions are not the best place to provide care.
Favorable legislation such as AB34 and SB1485.
Strengthening expertise in jails, specific training in substance abuse and mental health issues.
Revision of laws on involuntary treatment (whether or not this is an opportunity depends on your point of view.)

Threats

Deficit issue in the Department of Public Health.

Acute needs of inmates—serious substance abuse and mental health issues, often complex medical care situation.
Take advantage of current political climate, supportive of treatment. This could change at any time.
Right now there is a Democratic legislature and a Democratic governor, so it's easier to get the changes we need in the overall system.
Much of what's happening in legislation now could not have happened under Governor Wilson and the previous legislature.

Ms. Deger: NAMI-Philadelphia has a program to educate judges. Mr. Munns: I would like to see information on that.

Ms. Gilleran asked about the Executive Steering Committee. Mr. Munns: The ESC is a body that provides oversight to the MIO project. Almost all the key players are represented there. We're looking at using this body as the coordinating body for all areas of coordination, not just for this MIO grant.

Ms. Gilleran: Under what auspices does the ESC meet? Mr. Munns: What pulled the group together was the SB1485 grant. Ms. Gilleran: Will it continue to function? Mr. Munns: Yes, but it's not clear to what extent. We are reorganizing the Committee. We're looking at the basic questions. The MIO Project will only handle 100 people. This is the research design. But there are broader issues to be taken care of and there is no other group that could act on the recommendations in the overall plan.

Ms. Gilleran: Different groups are involved in the ESC, and sometimes their interests are polar opposites. Is there any long-term hope? Mr. Munns: If not for the MIO grant this group probably would not meet again, but if they want the money, they have to keep meeting. The total grant for the MIO Project is $5 million.

Ms. Deger: The Public Defender's Office is also a big hurdle in creating special programs. Mr. Munns: Some of the discourse between the Public Defender and other members of the ESC was hot and heavy. Sometimes what is legally in the best interest of the client is not what's clinically in the client's best interest.

Mr. Agar: What's the implementation timeline? Mr. Munns: Four years. The actual hiring has been started by Citywide Case Management, which was the successful bidder. They are planning to start the Project by October 1.

Ms. Gilleran: In conversation with some providers, these particular providers were concerned about not having places to put people if they are not in jail. Mr. Munns: This is a major concern with an intensive case management program. It's not clear what will happen with the MIO Project. Citywide Case Management will be able to broker some services, but they will not be able to afford to pay for residential treatment services for their clients on any consistent basis.

Mr. Shipley: When released, the offenders have nothing in their pockets but $200. Their SSI has been discontinued and they have to link up with services before the probation officer catches up with them. Mr. Munns: There is a 3-6 month period before SSI can be re-started. Mr. Shipley: Also the offender may not be able to apply for GA. One reason there is a high recidivism rate is that there's nothing there for offenders when they are released.

Mr. Munns: The ESC has discussed the issue of eligibility, but unfortunately the Department of Human Services was not represented in the discussion. I think it would be a natural thing to expand the ESC to include DHS and the Social Security Administration.

Ms. Chartrand: I'd suggest adding the Department of Rehabilitation to the ESC as well. Mr. Munns. That's a good idea. I like that.

IV. DIRECTOR'S REPORT

Mr. Munns reported for Jo Ruffin as follows: I thought Jo would be here tonight, but she had a minor setback and her return is now scheduled for October 25th. She said she misses all of you.

I wanted to give you an update on the union situation with regard to the residential treatment facilities. All of the unions accepted the proposed one-year agreement. So all programs are running and no strike is planned now for next year's contract.

The planning process for the Single Standard of Care is moving along well. We've been impressed with the turn out and people's candor about what's working and what's not. I think we will get the best bang for the buck with this extra money, which we would not be getting without community input.

Mission Rock Homeless Shelter has been forced to terminate its services as of September 15th due to the construction of the new ball park. As a consequence, we had to manage to reduce the census from 300 to 200, and staff worked feverishly to find placements and shelters, as well as doing mental health and substance abuse assessments, and getting people into treatment on a priority basis. The transition is working as well as could be expected with this size population. Lots of staff have been working evenings and weekends to make this work, and I want to commend them. There is an impact on other programs. Right now the South of Market Mental Health Clinic is closed for other admissions, and Mission Mental Health is being impacted, too.

Ms. Brooke: In July we had a meeting with representatives of the Police Department and Tomas, Tom Ammiano's assistant, on the Police Crisis Intervention Project—a $180,000 project to train 30 police officers from throughout the City. This was not an easy meeting, and I want to commend Collins for making it really work.

V. MHB COMMITTEE REPORTS

Executive Committee

Ms. Gilleran: Our Helynna—it's hard to hold her down—was in the Bay Area Business Woman newspaper. They announced her appointment as Executive Director of the MHB and included a photo. Ms. Brooke: April was the person who made the contact and made the article possible.

Ms. Gilleran: Helynna also had lunch with State Center Jackie Speier and was introduced on the floor of the California State Senate as representing the Mental Health Board.

We received our program review for the Board and got a 4.0 rating, which means "commendable or exceeds standards."

Program and Services

Mr. Shipley: We had an update on the Treasure Island housing. We held the Program Review Training. Rich was very helpful with this, and the discussion was excellent. The programs we've chosen to review are:

Baker Places Assisted Living Program
Citywide Case Management & Community Focus
FSA Geriatric Services West
Richmond Area Multi-Services
Westside Assertive Community Team
Oakes Children's Center
Mission Assertive Community Team
Multi-Service Center South
Mental Health Rehabilitation Facility

Mr. Munns: It's certainly amazing the job you do on program reviews. I'd like to put in a plug for next year for reviewing more children's programs. Children's Services is now over 25% of the CMHS budget or about $30 million.

VI. PUBLIC COMMENT

Mr. Kalman: The election is taking place this November. The debate a week ago was disappointing. There was nothing on mental health. The situation is getting worse. I'm proposing that we see if we can put mental health questions into these mayoral debates, and can we give them questions on questionnaires which will be their blueprints for the next 4 years.

Mr. Agar: I'll respond to Shawn's letter.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:14 p.m.

DPH

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MEETING OF THE FULL BOARD

Wednesday, October 13, 1999
1380 Howard, **Room 537**
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A A. Approval of September Minutes B. Approval of Leaves of Absence for October	5 minutes
III. PRESENTATION Ed Harrington, Controller for the City and County of San Francisco will present information about the budget process, and suggest strategy to the Board for budget planning for CHMS.	45 minutes
IV. DIRECTOR'S REPORT	30 minutes
V. COMMITTEE REPORTS • Executive Commitee, Chair's Report • Additional Committee reports as needed	15 minutes
VI. PUBLIC COMMENT PERIOD	10 minutes
VII. ADJOURNMENT	

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UNADOPTED MINUTES

Wednesday, October 13, 1999, 6:30 p.m.
1380 Howard Street, Room 537
San Francisco, California

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D. (Chair); Tim Agar; Jim Beauford, Ph.D.; Millicent Bogert representing Supervisor Sue Bierman; April Martin Chartrand; Toye Moses, Ph.D., M.P.H.; Gloria Samayoa; Mickey Shipley; Lora Traveler; Chester Villalba.

BOARD MEMBERS ON LEAVE: Renee Deger; Darwin Dias; Brian Peagler.

BOARD MEMBER ABSENT: Barbara Williams.

OTHERS PRESENT: Collins Munns (CMHS); Deedee Jenson, (California Institute for Mental Health), Rebecca Prozan (Mayor's Office); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Chair, at 6:38 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-99-36): Be it resolved that the minutes of the Mental Health Board meeting of September 8, 1999, be approved as submitted. (Passed)

RESOLUTION (MHB-99-37): Be it resolved that the Mental Health Board grant leaves of absence for the October 13, 1999, meeting to: Renee Deger, Darwin Dias, Brian Peagler. (Passed)

III. PRESENTATION: ED HARRINGTON, CONTROLLER OF THE CITY AND COUNTY OF SAN FRANCISCO

Ms. Gilleran introduced Mr. Harrington as follows: Everything we do is underwritten by the issue of money. The person we have with us tonight to make the presentation is Ed Harrington who has been the Controller of the City and County of San Francisco since 1991 when he was appointed by Art Agnos. He manages $4 billion dollars of City and County money. And we appreciate him taking the time to be with us tonight.

Mr. Harrington: I do the technical part of the budget and the Mayor and the Board of Supervisors do the policy part of it. But I can at least tell you some ways to get involved in the policy discussion about the budget. I'll just give you a short presentation, so there'll be time for your questions.

It's important to be aware of the cycle of the budget so you don't jump in there at the wrong time. A lot of organizations get hurt by coming into the process too late.

The cycle begins July 1st and runs through June 30th of the next year. It's really a cycle that doesn't end and that's part of the problem.

The Departments are putting their budgets together in the fall, because by February they need to give the Mayor's Office their budget proposals. Then the Mayor has the budget from the middle of February until June 1st. In the old days, before the 1996 Charter, the Mayor could only cut. That whole dynamic has changed. Once the budget gets to the Mayor, the Mayor can add, delete, and rearrange the budget. And Mayor Brown has certainly done that. He's added, rearranged, and cut.

On June 1st, the budget goes to the Board of Supervisors and they have very little time to analyze a $4.2 billion budget. Because they have such a short time, they have much less influence on the budget than the Mayor.

Harvey Rose, the analyst for the Board of Supervisors, can typically come up with $5-15 million of things to cut. This allows the Supervisors the chance to add back in that much of the things they want to support.

The Board's role is fairly limited. The Finance Committee of the Board of Supervisors holds hearings in mid June and then the Board votes in July. There is an interim budget during the month of July, but nothing new can start. At end of July the Departments know what their budgets are. And then they have August and September "off," but then start planning for the next budget in October.

What's discretionary? How much money do they have to play with vs. what's spoken for?

When you talk about a $4.2 billion budget, it's easy to say, Increase my program's budget by $5 million—it's such a small amount compared to $4.2 billion. But only a small part of the budget is discretionary.

There are a number of departments which are self supporting, such as the Airport and Hetch Hetchy. They spin off money to other services in some years, but mostly they're just self-supporting,

About half the budget is General Fund. These are things that typically don't make money, and within that there is a mix of funds. With Department of Public Health, a lot of the money that comes in is from state and federal sources and must be spent on certain programs or it goes back to the funding source. You can't move those funds over to another program.

Then you get down to about a billion dollars, still a big number, that comes from locally-generated taxes. Within that there are limits that are typically in the charter. We are a small "d" democratic city, and we put many things into the Charter, like the number of police officers.

There are also requirements due to the consent decrees. There are also a variety of things the voters have said we must have and those are in the Charter as well and so must be in the budget, like libraries and children's services.

So the real money that people can make a decision about each year is really a couple hundred million dollars or less.

And at that point you are competing against salary increases in the MOU's and you're competing against all the other programs.

San Francisco is either the model or the curse depending on your point of view. In other counties you go to the County to talk about a whole range of services. And there are a variety of different agencies responsible for different services. In San Francisco, you come to one place for everything: The Mayor and the Board of Supervisors. We have trade-offs that no other district in California has. So our situation is more complex and there is a lot more scrambling here because there are so many services competing directly with each other.

So the City of San Jose looks good, because it is covering a whole lot less services than City and County of San Francisco. It is not covering social services, and transportation, for instance.

Recreation and Parks will be on the ballot to protect their funding. Muni will have its money protected. And this is a problem for services that are not protected.

Mr. Harrington then reviewed a handout he had brought with him. He noted that the Department of Public Health has a total budget of about $800 million, with about $230 coming from General Fund.

Dr. Moses: I have a general question. What the Mental Health Board does best is advocate, and we advocate for consumers. In the past in Public Health, we always ask for more money so we can better serve consumers. What do you think we can do to be more effective, because we really care about consumers. And we think if you don't care for them, they can do some things we don't like. What advice can you gives us?

Mr. Harrington: To the extent that people are strong and vocal advocates, that makes a difference. At every level, with the Board of Supervisors, with the Mayor, if they see 5 people, they assume there are more people behind them. Calls to Board members or their staff can make a difference.

When Mayor is putting his budget together he goes to his allies on the Board and asks them what they are concerned about, and if you are a top constituency for that Board member, that makes a big difference.

With regard to tactics, Coleman Advocates have been very effective. The Children's Fund wouldn't have been set up without them. Some people view them negatively because of their tactics, but they have been very effective.

Being organized and having good spokespeople is crucial. Also being reasonable enough, and having a back up plan, that is scalable, that you can ratchet up or down. So you can say, We're asking for 15, but if you give us 5, then here's what we can do.

Mr. Villalba: Do Departments have long range plans so citizens and the Board of Supervisors would know what that Department's big picture of planning is?

Mr. Harrington: The City is not good at planning. I don't think that comes as a surprise. We look one year ahead. The Charter requires us to do a 3-year budget now, but we don't do it. In the Spring we take a look 3 years into the future, but that's a global look. Supervisor Newsom has just introduced legislation that will make the 3-year budget more explicit. It's hard enough to make decisions for 1 year let alone 3 years. It's not in the politician's interest to tell us bad new s that's 2 years in the future.

In response to a question about policy, Mr. Harrington replied: We've made policy statements such as Treatment on Demand, and every year more money goes into that effort. Clearly having those policy statements makes a difference. Waiting for a global planning process may not serve you well. And as advocates you don't have to care about all the other things out there. That's our job to look at the big picture.

Ms. Gilleran: When you say policy what do you mean?

Mr. Harrington: With treatment on demand, the Board of Supervisors passed a policy statement that was vague enough that people didn't oppose it, but specific enough that it makes a difference. There was no time frame stated.

Mr. Agar: I think our particular cause in mental health is the Single Standard of Care. That's our mantra.

Mr. Harrington: And it's not as clear as Treatment on Demand. They don't know what it means, and it is complex. However, many of the issues of mental health are very apparent to people in the city and certainly to elected officials.

Ms. Brooke: But we need to come up with our "got milk" phrase.

Mr. Harrington: And don't underestimate the important of a Champion. Mabel Teng went after childcare issues a couple of years ago and kept after it. She was single-focused enough that people know if they wanted her vote they needed to support childcare.

Ms. Bogert: Single standard is a good example of a champion. That went through because of Sue Bierman working with advocates and the Department, ratcheting different levels of service. At the end of the day the Mayor came in and said, Do you want this money?

Mr. Harrington: I was in the room when that happened. And if Sue hadn't said yes the Single Standard wouldn't have happened.

The dynamic will change with this coming election and you need to figure out how you fit into the new dynamic.

Mr. Shipley asked about subaccount transfers, specifically transferring money from mental health and not returning it.

Mr. Harrington: The Board of Supervisors adopts budgets by Departments, so transferring money from one Department to another is a very rare thing, and that has to go through a public process. But transferring money within a Department is allowed. For example when San Francisco General Hospital is in trouble, the Department of Public Health has transferred money from other programs. Typically you don't transfer more than 15% of a program's funds.

In DPH, it's such a huge budget and so complex, every year we've had to come back in the middle of the year for a supplement of $20-25 million and things get transferred around at that time.

In the Department of Human Services, most programs are required by the federal government. But General Assistance is not, and that's why people look at GA for cuts.

Mr. Villalba: With regard to Lagunda Honda, it's still unclear to me about the tobacco money.

Mr. Harrington: There are still risks to the tobacco money. You may get 40 cents on the dollar. We think it will be better than that. The City is probably going to get the money. If we're horribly successful and the tobacco companies go out of business, then who's going to pay the money? But if they settle and people still smoke and die then it's a trade off.

Ms. Brooke: Is there a central person in Mayor's office who looks out for federal and state money?

Mr. Harrington: It's some of both. The people who are experts in substance abuse are in the Department. But we try to organize going after funds in a centralized way. Our lobbyists are looking out for sources of money. And the Departments are members of associations which are following money, too. And then we have a coordinating group so we don't duplicate grant proposals. And this allows for the building of more multi-department proposals which might look more interesting to a funding source.

Luckily we're San Francisco and the local representative for HUD is Art Agnos. Also we have good lobbyists in Washington, D.C., and we get alerted to more of the money than most places.

Ms. Gilleran: Have the funds that are protected achieved that status by legislation?

Mr. Harrington: Protected funds come about in a variety of ways—through the Charter, through the ballot, or by majority vote at the Board of Supervisors. For example we are mandated to have Muni and cable car service as it was in 1971. There are other protections that are not legislated. For example the Sheriff's Department has requirements it must follow because of a consent decree. If we violated that, we'd be back into court.

Matching funds help protect dollars. If you can show that cutting one DPH dollar, means losing ten dollars of service then it doesn't make sense to cut. So things that are totally funded by the General Fund, are targeted more.

The first precedent for a specific fund was the Children's Fund, which locked in a percentage of the budget. And it must grow generally speaking at the same rate as the rest of the budget and the property tax revenue. So $50 million has grown to $60 million.

Mr. Agar: That could shoot you in the foot.

Mr. Harrington: The question is, Is that a floor or ceiling amount? But in fact, we've always exceeded the percentage locked in by the Children's Fund, and we're usually over it by a couple million. But as you protect more and more of the budget, what's left?

Mr. Agar: How common is our Charter system?

Mr. Harrington: We're the only City and County in California. And counties don't have charters. It's more typical of old back east cities. We're so activist in San Francisco—many charters are 10 pages and very general in terms of vision, but our charter runs to several hundred pages. People who know charters are shocked at the level of detail in our charter.

Ms. Brooke: What advice do you have for us on how to work with the Supervisors, once they are elected from districts.

Mr. Harrington: My biggest fear is that you will be in a protected mode for a while. Supervisors will get protective of districts and no one wants a group home. And so I think you might have your hands full defending services. The politics will get more local than they are already are.

But the district Supervisors will be hearing from fewer people. So it would be important to have people from in the district speaking to them.

Ms. Gilleran: I know you were appointed in 1991 for a ten year term. Will you be reappointed in 2001?

Mr. Harrington: It's possible. It was set up to be an independent office—ten years, or removal for cause. It was a lifetime appointment in the 30's when originally set up. No one has been in the office for the full ten years since it changed to a ten-year term.

Ms. Gilleran: Thank you! This has been one of the most important discussions we've had on such a crucial issue. We hope you continue as Controller.

Ms. Brooke: I want to introduce just before she goes, Rebecca Prozan from the Mayors' Office. April ran into her a couple months ago. And she is our contact with the Mayor's Office.

Mr. Agar: Could you tell us about your job?

Ms. Prozan: It's difficult to describe. Most of us in the Mayor's Office do all kinds of things and then some. I work on gay and lesbian issues, women's' issues, the women's summit, taxicabs, and I cover several districts of the city. It's a lot of issues, but I like it that way, it keeps me on my toes. I don't know if I'm the most appropriate person to do mental health. Next month I could bring the budget person.

I'm not technically the liaison to the Board. I have a contact with April. Is mental health my strength, no, but can I act as a conduit, yes. My phone number is 554-6148. If the Board wants to come to some kind of consensus about 3-4 issues you want to discuss, I could bring reps from the Mayor's Office to address them.

IV. DIRECTOR'S REPORT

Mr. Munns reported for Jo Ruffin as follows: Just a brief report tonight. Jo will be returning on October 24th, barring something catastrophic, and will be with you at the next meeting. I will be delighted to have her back.

Next I want to discuss the budget process that's just warming up now. If you think of the budget as Ed Harrington was describing as a continuous cycle, there's something we're dealing with in the current year which represents a challenge for next year. We have a salary savings goal that is too high to be reasonably met. What I mean by salary savings is that each Department is given a number to meet, and usually it's not a problem. Normally attrition and turnover, plus savings from vacancies, which take time to fill takes care of the problem.

A salary savings target of ten percent has been implemented. But this is too large. Normally in a large organization, you will have a 5% salary savings. This means that we have a 5% salary savings problem, which translates into a half a million dollars. So we have a problem this year and have to look at the next fiscal year. When an administrator has a choice between cutting a budget and salary savings, you go for salary savings because it seems painless. But if you do that year after year, at some point it's not sustainable.

We're working on a plan to solve that for this year and next year, and will bring that back to you. This is a heads up.

I also want to let you know that what may be the final meeting of the Single Standard of Care Planning Group will be on October 24th. It's been a very interesting process. Not everyone is happy with the outcome, but I think most participants have been pleased with how it's gone. I, for one, have learned quite a bit from that process. I think we have increased our cadre of stakeholders who are willing to be support for mental health.

A final note: I received a summons from my wife—she wants me to come home to San Diego. I've been commuting for the past three years. I've submitted my resignation and I will be leaving here sometimes around Christmas. But I will be here for your November meeting and perhaps will be able to join you at your Retreat. But I wanted to give you the news that I'm going to be going home.

Mr. Villalba: A question about the salary savings. Are you now short on staff? Are there areas where you are not well covered staffing wise?

Mr. Munns: There are a couple factors. The normal rate is 5% and you can get that pretty easily in large organization. For reasons that aren't clear to us at this point, the retention rate has gone up from 5% to 3% and that seems like a small number, but it's several hundred thousand dollars. Usually when you have good economic times, you get a higher turnover. We're in good economic times, and we're not sure why we're having such a high retention rate.

We have had a backlog of positions that have gone unfilled from the hiring freeze last year. So there is a wave of positions that we are filling. But we've had to halt those and see which positions can be delayed. and we'll present those to you at the next meeting.

Ms. Traveler: What do the salary savings do? Do they help the mental health client? Where are the savings going?

Mr. Munns: Think of salary savings as an integral part of the budget. If you were the donor and you were funding services and they cost $100 million, you would only have to give $98 million with a 2% salary savings. You could then say to the funder, Give us that $2 million and we'll use it for programs. But that would be up to the funder. It's typical to fund at less than 100% because the Department can't spend all the money in the budget due to vacancies in positions.

Ms. Traveler: Collins, we certainly are going to miss you from our meetings. Thank you for all your help, and all the things you've done.

Mr. Munns: It's been a wonderful three years.

Mr. Shipley: You've been very, very active in helping to get the Police Crisis training going, and will you continue to push until the day you leave?

Mr. Munns: I certainly will. The meetings will continue in December. Jo will assume my role in December, and we both are committed to this program, and it's going to be a long drawn out process. We're going to start in the Tenderloin. If the Police Department is committed to training 2,000 officers, which is what they are talking about, that's going to take years. The training has got to be intense because it has to be done in fairly small groups.

Mr. Shipley: What I've understood that is you've been very diplomatic and assertive in getting this process done.

Mr. Munns: I don't want to overstate that. People like Marykate Connor from Caduceus have been out there for years fighting this battle. I'm a relative newcomer.

Ms. Gilleran: This is very stunning news that you are leaving and it's not what we wanted to hear for Christmas; I'm glad we have a couple months left. But I think everyone here understands the importance of family.

Mr. Agar: In the time I've been on the Board, you've been a mentor to me in the way the system works. I think it's sad in a way that you're leaving, because the system is so complex and you've become so successful in navigating the system, and guiding us. I wish to commend you and I wish you all the best.

V. MHB COMMITTEE REPORTS

Executive Committee

Ms. Gilleran: First I would like to introduce Deedee Jenson, who is here from the California Institute for Mental Health. She'll be coming to our Executive Committee meeting in November to talk with us about our Retreat.

I'd like to urge you to read our Snapshot; it's chock full of news. It has more information than you'll get in the *Examiner* at night.

We had a really lovely gathering for Maria Leib the other night. Maria was certainly a remarkable Chair. And for the years before she was Chair, she was a deeply-dedicated member of the Board. She received a proclamation from the Board of Supervisors. There's not enough we can say about her, and it was lovely to see her again.

Lanterman-Petris-Short (LPS) reform meetings are coming up. The Bar Association debate is coming up October 21, but we were dismayed to learn that it costs $30 to attend. Lora and Mickey will attend on behalf of the Board.

We will be co-sponsoring with CMHS an LPS Forum for San Francisco. More news will be coming up on that.

At the next Executive Committee meeting we will have a very in-depth discussion about our Retreat. The Retreat is of the greatest importance, and I hope all Executive Committee members will attend that meeting and that all members of the Board are planning to attend the Retreat on December 4th. At the Retreat, MHB Committee Chairs will be asked to give summaries of what they've done during the past year.

Children's Committee

Dr. Beauford: Last meeting we found out that there was additional money coming from Supervisor Yee's office to CMHS Children's Services. The total amount is $275,000. Supervisor Yee is interested in a youth hot line. We brainstormed a list of ideas, and hope that he can dovetail his priorities with some of our ideas. Right now communications in children's services is fragmented, and we hope more than just the hot line can be done. Perhaps a website can be developed to pull together the fragmented information. Perhaps an information clearinghouse could be set up.

Mr. Agar: I just want to comment on the Cultural Competency and Special Populations Committee. If you have not had a chance to tour the Cecil Williams Glide Community House, you might want to contact Helynna to arrange that. I want to emphasize how important it is to have the kind of wrap around services that facility emphasizes.

Ms. Brooke: I just want to thank all of you who did program reviews. People did an incredible job. And you were very well received at the agencies. This was an unreasonably short period of time this year that we had this year to do reviews, and next year we're going to fight back and begin in January and give them our schedule for doing reviews. You were all awesome.

VI. PUBLIC COMMENT

Mr. Kalman: I would advise everybody to get the financial report which the Controller puts out annually. I think there is a problem. If the Mayor needs emergency money, it's miraculously produced. The only way to follow what's going on is to have the financial report. You can get a copy directly form the Controller's office. Also I recommend getting a copy of the Mayor's budget, not only the summary, but the whole budget going back a few years. Some programs have just completely gotten wiped out from the budget, especially early prevention, and this is one of the most important things in mental health. And we need specialized training for the police officers.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:22 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE FULL BOARD

Wednesday, November 10, 1999
1380 Howard, **Room 537**
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A A. Approval of October Minutes B. Approval of Leaves of Absence for November	5 minutes
III. PRESENTATION Sai Ling Chan-Sew, Director of Child, Youth, and Family Services for the City and County of San Francisco, will give an update on Children's System of Care and an overview of coordination efforts between Community Mental Health Services and the Juvenile Justice System..	45 minutes
IV. DIRECTOR'S REPORT	30 minutes
V. COMMITTEE REPORTS • Executive Committee, Chair's Report • Additional Committee reports as needed	15 minutes
VI. PUBLIC COMMENT PERIOD	10 minutes
VII. ADJOURNMENT	

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

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Come give us your input on...

INVOLUNTARY
Mental Health Treatment

The California legislature is looking at reforming state laws about the rights of citizens with regard to mental health treatment. It's called Lanterman-Petris-Short reform or LPS. Here's your chance to be part of the process early on, before any new laws are written.

What do you think about the current laws which govern involuntary treatment? Should the laws stay the same? Should the laws change? What's working, what's not? There's been talk of involuntary commitments to outpatient treatment. What are your thoughts and feelings about that?

LPS Forum
Tuesday, November 16, 1999
from 1—4:30 p.m.
Koret Auditorium, Main Library
San Francisco Civic Center ♿

Please come and speak. Tell us your concerns and your personal experiences. The Forum is not a debate, but a genuine effort to understand key arguments on all sides of the question. We'll be seeing what common ground we can find.

LPS is a very complicated and controversial issue. Good people can have serious disagreements with each other on LPS. The Forum will be a chance for all sides to present their ideas and concerns in an atmosphere of respect and honest inquiry. The information gathered will be taken back to the state legislature.

We're hoping that the widest possible range of people from all the different communities in San Francisco will come speak. We're hoping to hear from mental health clients, family members of clients, service providers, policy makers, legal advocates, and any and all other interested citizens.

No time like the present...to influence the future!

This Forum is sponsored by the Mental Health Board and Community Mental Health Services, and is supported in part by the following sponsoring organizations of the Statewide LPS Dialogue Project: California Department of Mental Health, California Association of Local Mental Health Boards and Commissions, California Mental Health Planning Council, California Institute for Mental Health, and the California Mental Health Directors Association.

American Sign Language is available if requested, or for other languages, call 5 days in advance of event: MHB: 415-255-3474.

SAN FRANCISCO MENTAL HEALTH BOARD

November 10, 1999

The Minutes of this meeting are missing.

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Agenda

The Mental Health Board meeting scheduled for December 8, 1999, has been CANCELED

The Board will be holding its Annual Retreat on Saturday, December 4, 1999, in Pacific Conference Room B at the San Francisco Marriott Hotel at 4th and Mission Street, from 9 a.m. to 4 p.m.

No final votes will be taken by the Board at the Retreat. Any proposals or resolutions developed by the Board during the Retreat will be placed on the agenda to be voted on at its next regular meeting on **Wednesday, January 12, 2000.**

An agenda for that meeting will be sent out at the beginning of January.

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SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE FULL BOARD

Wednesday, January 12, 2000
1380 Howard, **Room 537**
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A 1. Approval of November Minutes 2. Approval of Leaves of Absence for January	5 minutes
III. PRESENTATION Consumers, Family Members, and Providers will present a range of different perspectives to the Board on LPS Reform in general, and specific responses to AB1028. Panel members are: George Bach-y-Rita, Steve Fields, Renee Deger, Jerry Veverka, James Jonasson, and Carol Patterson and Roy Crew.	60 minutes
IV. DIRECTOR'S REPORT	15 minutes
V. COMMITTEE REPORTS • Executive Committee, Chair's Report • Cultural Competency and Special Populations Committee Resolution to Support Significant Funding for the Statewide Supportive Housing Initiative (Attachment B) • Additional Committee reports as needed	15 minutes
VI. PUBLIC COMMENT PERIOD	10 minutes
VII. ADJOURNMENT	

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City and County of San Francisco

Department of Public Health

December 17, 1999

Dear Interested Consumer:

RE: **Department of Public Health Strategic Planning Initiative**

I am writing on behalf of the Director of Health to assess your interest in serving on a committee of the Department's strategic planning initiative.

The San Francisco Health Commission recently established a process for strategic planning for the future direction of the Department of Public Health. This process recognizes that the demographics and health status/ problems of San Francisco are evolving as the City grows and changes. In addition, there have been changes in federal, state and local government policies and funding that must be considered as the Department prepares for the next decade. These changes require that the Department develop a strategy for identifying and prioritizing its future activities given its mandates and funding levels.

To develop this strategy, the Health Commission has appointed a Strategic Planning Steering Committee to oversee the process and two subcommittees to prepare analyses and recommendations in the broad areas of their charges (see Attachment B). Efforts to identify consumers to participate when the committees were originally formed did not result in consumer representation. Our goal is add two consumers of health services (ideally Department services) to each of the committees. We are also seeking consumers who have knowledge of or have used one or more of the Department's services – e.g., mental health, substance abuse, long-term care, San Francisco General Hospital, district health centers, etc.

If you are interested in participating as a committee member, please complete the attached form and **fax or mail it to Dick Hodgson (fax: 554-2622; mailing address at bottom of this letter) by Friday, January 14, 2000.** I believe our strategic planning process is an excellent opportunity for consumers to play a role in the strategic direction of the Department and I urge you to participate as a committee member or, alternatively, to provide your input as a non-member. All Committee meetings are open to the public and information is posted on our website at: **www.dph.sf.ca.us/ stratplan.**

Thank you for your interest in the Department's strategic planning initiative.

Sincerely,

RGH for

Tangerine Brigham
Director of Policy and Planning

Attachments

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH STRATEGIC PLANNING INTIATIVE

GOALS AND OBJECTIVES

The goal of the strategic planning initiative is to position the Department to fulfill its mission and vision as the demographic profile and health status/problems of San Francisco evolve over the next 5-10 years. Objectives to address the goal include the following:

- **Community Planning**: work with the community, other providers and City agencies to improve health status,
- **Funding**: address funding and legislative/regulatory changes within health (federal and state),
- **Integration**: further expand integration activities within the Community Health Network and Population Health and Prevention to create a seamless care delivery system.
- **Prevention**: strengthen prevention activities and
- **Prioritizing Program Development and Populations Served**: ensure that the Department develops a mechanism for prioritizing the services it provides and the populations it serves.

COMMITTEE STRUCTURE

A **Steering Committee** comprised of Department staff, key stakeholders and community representatives oversees the strategic planning process. The Steering Committee reports to the Director of Health. The Steering Committee makes recommendations to the Director of Health who approves and presents those recommendations to the Health Commission for review, approval and/or modification. Two sub-committees report to the Steering Committee:

- **Populations and Programs** – examines strategic questions related to and prioritizes populations served and programs provided by the Department.
- **Finance** – examines funding issues and develops an overall proposed funding strategy related to program priorities.

Each sub-committee also has members representing the Department, key stakeholders and the community.

STATEMENT OF CONSUMER INTEREST
San Francisco Department of Public Health Strategic Planning Initiative

Fax or Mail to Richard Hodgson by Friday, January 14, 2000
Fax: 415-554-2622
Mail: Policy and Planning
101 Grove Street Room 324
San Francisco, CA 94102

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Organization: ______________________________

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- ___ Mental Health
- ___ Primary Care/ District Clinics
- ___ Laguna Honda Hospital
- ___ STD/Communicable Disease
- ___ Senior Services
- ___ Other (please specify): ________________________

DPH

MENTAL HEALTH BOARD OF SAN FRANCISCO

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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UNADOPTED MINUTES

Wednesday, January 12, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D. (Chair); Jim Beauford, Ph.D.; John Henry Pearce representing Supervisor Sue Bierman; April Martin Chartrand; Renee Deger; Darwin Dias; Pat Harrison; Toye Moses, Ph.D.. M.P.H.; Brian Peagler; Mickey Shipley; Lora Traveler; Chester Villalba.

BOARD MEMBERS ON LEAVE: Tim Agar; Barbara Williams.

BOARD MEMBERS ABSENT: Gloria Samayoa.

PRESENTERS:

Carol Patterson, Consumer, San Francisco Representative of the California Network of Mental Health Clients

Roy Crew, Consumer, Executive Director, Office of Self Help, former member of the Mental Health Board

James Jonasson, Consumer

Renee Deger, President of NAMI—San Francisco, current member of the Mental Health Board

Jerry Veverka, Family Member, former member of the Mental Health Board, former President of the California Alliance for the Mentally Ill

George Bach-y-Rita, M.D., Provider, Psychiatrist from San Mateo County

Steve Fields, Provider, Executive Director of Progress Foundation

OTHERS PRESENT: Jo Ruffin (Director, CMHS); Tina Yee (CMHS); Linda Wang (CHMS); Mark S. Adamek (San Francisco Network of Mental Health Clients, and San Francisco Depressive and Manic Depressive Association); Emeric Kalman (Family Member); Marion A. Keller, L.C.S.W.; John Brauer (Community Vocational Enterprises); Vivian Imperiale (Community Vocational Enterprises); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Chair, at 6:37 p.m.

II. CONSENT CALENDAR

> **RESOLUTION (MHB-00-01): Be it resolved that the minutes of the Mental Health Board meeting of November 10, 1999, be approved as submitted. (Passed)**
>
> **RESOLUTION (MHB-00-02): Be it resolved that the Mental Health Board grant leaves of absence for the January 12, 2000, meeting to: Tim Agar. (Passed)**

III. PRESENTATION: REFORM OF THE LANTERMAN-PETRIS-SHORT ACT

Ms. Gilleran: The presentation tonight is a discussion of the Reform of the Lanterman Petris Short Act, which was introduced as AB 1028 by Assemblywoman Helen Thomson, and has now been reintroduced as AB 1800. It's very timely to have this discussion so we can provide our input to those who are carrying AB 1800.

The way we have designed the panel is we have set up two consumer presentations, two family member presentations, and two provider presentations, and people will be speaking from different points of view. There will be ten minutes per speaker.

Mr. Jonasson: I've written my remarks and I'm going to read them so my thoughts come across as clearly as they can.

There are two things you should know about me before I start my discussion on LPS Reform. First I am someone who suffers from a neurobiological disorder, a mental illness. I am fortunate in that medication has controlled my illness and its symptoms for the eleven years that I have taken it.

Second, I am an employee of San Francisco's Community Mental Health Services. This fact you must put aside. I am speaking for myself and for no one else. No one has put words in my mouth nor thoughts in my brain. I am a private individual exercising my right to free speech. I am speaking for myself and myself alone.

Third, I am entirely in favor of the proposed LPS Reforms. I believe that someone suffering an acute psychiatric episode cannot make a rational decision about his medical care and what may be considered his civil rights. Until such a person can be psychiatrically stabilized I believe his judgment is impaired and he cannot choose the best course for his medical treatment. If he requires more than 3 days or 3 weeks in a hospital, so be it. Leaving the hospital in the shortest legal time rather than the time required for stabilization is not in the person's best interest, nor is it in the hospital's interest. If I were to go off my medications, it would take 2 or more weeks to achieve the therapeutic level again. Released too early, a person may quickly become in need of hospitalization again and the hospital will have to again provide services which might have been used by another and at additional expense.

The worst case, of course, is that this unstable person injures or kills himself or someone else. The issues of adequate care and civil rights don't come up much in medical emergencies of a physical nature. For example, when driving, you spot a car in a ditch.

You investigate and find a man in shock. His arm is bleeding profusely. You disregard his protest that he is fine and tie off his bleeding. Then you secure safe transportation for him to an emergency room. It is you and not the car crash victim who makes the decisions for his treatment. And it is right that you do so.

Who knows more about the psychiatrically ill person's correct treatment, the doctor or the patient suffering from an acute episode? Furthermore, I find the notion that one can exercise his civil rights appropriately while irrational due to psychoses, delusion, or hallucinations and other symptoms of mental illness, simpy ludicrous.

I believe the proposed changes to LPS will benefit those who suffer from mental illnesses and relieve the hospitals of some unnecessary burdens of care and their attendant expenses.

Ms. Patterson: I'm the coordinator of the BUILD program which does peer counseling and works a lot with people with psych disabilities. I am a consumer with a psych disability. I'm our agency's point person on forced treatment.

I have two handouts for you. They are from CARES , which is the Coalition of Advocates for Rights Empowerment and Services. They include a 6-point position statement opposing the expansion of forced treatment.

Some other folks have roughed out another bill which would fund additional voluntary services. From my point of view that's the answer. The only thing I would agree with in AB 1028 or AB 1800 is funding for the expansion of services, if they are voluntary.

I was hospitalized involuntarily in 1978. What got me hospitalized then would not get me hospitalized today. The law hasn't changed; what has changed is the availability of beds. When people say why wasn't someone hospitalized when they were gravely disabled, I actually agree with every such story that I hear. But the reason they weren't hospitalized is because the beds were not available.

If this bill is passed the mental health system will go bankrupt. What will be funded is involuntary commitment.

The second handout I have for you tonight is about a report that's going to be released on January 20th by the National Council on Disabilities. There are ten points. Laws that create involuntary treatment should be suspect because they undermine the clients empowerment. Mental health treatment should be about treatment not punishment.

My concerns about the expansion of involuntary treatment include how this law emphasizes taking medication. It requires people to be involuntary consumers of the drug companies. Drugs are very expensive, and some of us can't afford them. So we go off our meds, end up in the hospital, and the county then pays for the meds.

This law assumes that meds always work. They don't always work. The surgeon general reported that with 1/3 to 1/2 of people who are given psych medications, the first meds they are given don't work. Forced treatment will squash the voices of consumers who want to say that their meds are not working for them.

The words involuntary treatment are not mentioned in AB 1028. The word wrap-around is used, but they are really talking about involuntary commitment. It makes me feel as a consumer that I wouldn't rock the boat at all or I wouldn't get out of the hospital.

There is the case of a client in San Francisco who disagreed about her meds and disagreed loudly and the police were called and she was 5150'd. What's the message for other clients: Don't disagree or you will be 5150'd.

Also meds are not benign. Research may have been done on the effects of the medication for only a period of 4-6 weeks, but what happens to a person who takes those meds for ten or twenty years?

Ms. Deger: I have a brother who has schizophrenia and that's why I do some of the activities that I do. This story was in the news recently: The day after a father allegedly stabbed his teacher, his son walked in and apologized. Paul Gonzales had not been taking his medications when he allegedly stabbed the teacher. Gonzales also apologized and said he had not been taking his medication.

Now this was a celebrated event, and a violent event, so it got a lot of attention. Unfortunately nothing is done until things get to that point. I can't tell you the number of times I've talked with family members about behavior they know to be dangerous and erratic. This is when family members do know about the mental illness, when a diagnosis has been given.

We wouldn't be having this meeting about Grandpa or Grandma who did something because of Alzheimer's. I really don't understand in this day and age why we consider brain diseases like schizophrenia as different. I know there is a lot of fear exhibited by people who fear that the status quo will be negatively impacted. But we are talking about the people we ignore, people who are being horribly mistreated on the streets. They are being murdered, they are being raped, they are being treated terribly. We're saying if we change the law, it may be ultimately be bad for people already in the system and I don't find that acceptable.

Think about what it's like for family members when they don't know where their family members are. Their biggest fear is that their children might be suffering out on the streets. I don't agree with letting people visibly suffer. I don't think we can get into academic discussions and ignore people who can't come in here to speak for themselves. This not a civil rights issue.

Mr. Veverka: This is a tough one for me. Even within my family, there is disagreement between me and my wife. When I weigh the issues, I come down barely on the side of opposing the LPS Reform. I agree with big pieces of what the other speakers have said tonight. I have a son who is schizophrenic. He's been stable on a medication that has bad side effects. He's a different individual than he was before. If there's one variable that's made the difference, it's the medication. Thank God, for the medication Eric takes.

If Eric was ever decompensated, incoherent, shoeless, out wandering the streets, I would do anything legally or illegally to get him stabilized. So why am I opposed to the Reform? I'm not worried about people like Eric. I'm worried about people who would be caught in the net.

I'm opposed to the expansion of involuntary commitment. I agree with Carol 100% on involuntary commitment. I think we are talking about implementation, not criteria. Anyone who is gravely disabled, needs help. Any of us with compassion will want to make sure that person is okay. I think the criteria for gravely disabled need to be defined so that any of us would agree on them. A person should not be allowed to crash and take with them the resources of family and friends.

When the issue of the expansion of involuntary treatment first came up as an issue about three years ago at the California Alliance for the Mentally Ill, good people were saying sensible things on both sides of the issue. At that time, I came down narrowly on side of civil liberties.

Another key issue is money. If we put money into involuntary treatment, who do we take it away from?

I'm worried about enforcement. Do we now cast providers as enforcers? I also think this is a short-term solution to a long-term problem. If we put people into the hospital and treat them, what about relapse? I think I'd rather have people engaged on a voluntary basis in a long-term solution rather than in an enforced program.

When I say my son is in treatment, he's not in treatment apart from the medication he's taking. The medication is what's causing him to be a happier, brighter, clearer person. My son is on Clozaril now, but did better ten years ago on Haldol. How can that be? Ten years ago he also had a girl friend. I'm not saying that girl friends and boy friends are the cure to mental illness, but that there is the human dimension and it makes such a difference. Medication is the factor that contributes to my son's wellness; it's working for his particular illness. But there are a lot of people who don't fit into this category.

Mr. Fields: I pretty much share a perspective with Carol and Jerry. I'm not as narrowly opposed to the Reform as Jerry, but I agree this is a complicated, volatile issue.

I believe the issue of Reform has been engaged much too quickly, and addresses certain problems with a draconian approach. Well meaning people on both sides are going to look at this issue and come away with the perspective that the LPS Act in this state was a bellwether for human rights. Change this big, this quickly made is a mistake. Assemblywoman Helen Thomson who authored the legislation, shut out input from communities. Her bill is the medical model of how to do legislation. She thought she had the right idea, and was going to push it through. This is too complicated and critical an issue to rush.

E. Fuller Torry connects violence and mental illness every chance he gets. The media almost always link violence and violent stories to mental illness. But all the studies show that's an erroneous, misleading and highly stigmatized way of looking at violence. So if they have to sell LPS Reform, by connecting violence and mental illness, that's a major problem.

I have some recommendations to address issues which we all feel are involved in the proposed LPS Reform. First, we need funding to develop the full array of services that we are just beginning to learn are the kind of services which will engage consumers instead of forcing them into treatment. Every time mental health comes to a crossroads, we always jump for social control. In a situation like LA County in the 70's there were no rehabilitation programs and the hospitals were flooded. But that did not mean that there should be involuntary treatment, it meant that they needed to open a complete system of care.

I'm concerned about the price tag of this bill which is $350 million. It's not clear where that money would go. If it goes to involuntary treatment, that could roll our system back to the 70's. It's important to know where the money is going. The State of New York spends $65 million a year just for the administration of Kendra's Law.

What we really need is a complete system of services. Clients tell us what they need: more services run by peers, more engagement. Relationships are the key to reaching out and keeping people active and engaged in their lives. The biggest key to success in my agency is if the client is engaged in taking the medications. We can keep people in the hospital, we can force them to take medications. But when they are back out on the street, isolated and alone, they will go off the meds.

It's not time to change the laws because of our inadequate treatment system. We have a fragmented system of care. We need a better idea of where people are going when they leave the hospital, and a better connection to where they are going. It's no surprise that people drop through the cracks. But we can fix that and that's one simple thing we can do to make a difference.

We also need more integration of mental health and substance abuse services. We need programs to bring the two together smoothly. And we need to be able to bring both to clients when they are out on the streets. Clients often end up in hospitals and jails, when there's no need for that happening. We're working on correcting that here in San Francisco. But we need some time to work it out. This is no time to jump to the reform of LPS. We need relapse prevention programs. There is no good study that shows that involuntary treatment works, or that they are any better than voluntary services.

We also haven't explored the option of Advance Directives clearly enough. This involves a client sitting down ahead of time with someone they trust and writing out how they want to be treated if they were to decompensate in the future.

The implementation of the current LPS law around California is a hodge podge of implementation. It's interpreted differently in different places. Conservatorship is implemented differently in different places.

Make no mistake about it, this LPS reform is rolling on a statewide and national basis. The fact that other counties implement LPS in a different way has impact on San Francisco. There needs to be a standardized way to implement the current LPS law.

I think our mental health system has made important headway in the past 5 years. We're on the way to making the changes we need to make. This is the worst time to fall back on LPS Reform, especially at that price tag.

Dr. Bach-y-Rita: I was in practice from 1969 through this past summer. Now I am an employee on the inpatient service at San Mateo County General, supervising young residents who are learning to work with the system.

I have a historical perspective on this. When I came into psychiatry, we viewed mental illness in very different terms than we do today. There's been an enormous change. Laing and Szasz wrote about the healthy adaptive response to what was insanity all around us. By the late 70's I was on the Board of Neighborhood Mission Health Center. I met with a group from Mexico, and they were shocked at seeing people wandering street. They said, "Even in Third World countries we take care of our people who are wandering the streets." We've become inured to people wandering the streets or sleeping in Golden Gate Park. This past year 147 homeless people died. Of the homeless population, 70% are people with severe mental illness. If we had 100 people die on the streets of syphilis, we'd call it a crisis.

I took trip to Wisconsin to look at their involuntary outpatient commitment. They didn't have homeless people out on the street. They were saving so much money from the reduction of inpatient services that they could afford to set people up in apartments and other housing. And a greater number of the mentally ill were being taken back into their families and didn't need outpatient treatment.

Medications have gotten better. It's become abundantly clear that we are dealing with a severe or series of severe illnesses of the brain. We're finding that obsessive compulsive disorder can be a consequence of a streptococcus infection. A substantial number of people with this disorder get better after a course of antibiotics. That's telling us the disorder is a response to an infection in the brain. Lou Gehrig's disease is caused by a virus. So much more is being discovered about the frontal lobes and schizophrenia. How will we adapt our care programs for people in light of this new information?

Stop and think, we already detain people involuntarily. In 1969, we had 36,000 people in hospitals. Now we have 3-4,000 in hospitals and 30,000 in jails. Do we want people in treatment or in punishment? More and more psych personnel are working in the jails, but these aren't programs. It's cruel to keep people in the jails. Changing LPS, we're not changing the fact that people are going to be taken care of in one system or another. If treatment is not there, our people will end up in jails.

Yes, we need more facilities, we need more commercially-run homes. I would rather see people going home to their families, but families can't take care of them if the patient's behavior is more than the families can tolerate.

Bipolar patients I could take care of in a private practice. Once their illness is under control, they are so aware, they take their meds. But schizophrenia is a different situation. The older meds disrupted people's ability to feel. The newer meds are not perfect, but are vastly improved. I hope in the next ten years we'll see much better meds.

Places like Wisconsin and North Carolina have a much better system than we have. As it is now the only care is in the jails and the government facililities.

At this point in the meeting, Colleen Johnson, Senior Legislative Planner with the Department of Public Health was introduced. She announced that the Board of Supervisors had voted this past week to support AB 1028. She noted, however, that since AB 1028 is being killed and replaced by AB 1800, the vote will have to be taken again.

Mr. Villalba: I'm curious to know how that got to the Board of Supervisors without some kind of dialogue with its own MHB.

Ms. Johnson: It didn't come to DPH, either. It was introduced by Supervisor Brown. Endorsements of legislation can come through the Mayor's Office or the Board of Supervisors. In this case the Board did the endorsement on its own.

Mr. Villalba addressed Mr. Veverka: You mentioned your son receives medication. Would you like him to be in treatment? Mr. Veverka: He was asked when he left the hospital what kind of mental health services he would like, and he said none. That's unconscionable, too. How can you ask someone who is denying his illness what kind of services he'd like? He lives in a Board & Care home which is where he wants to live, but to live there he has to take medication and he's not really been against it. But that's what he has to do.

Dr. Moses: I have a problem. Our aim is to support and advocate for consumers. When I quickly read through the information on LPS Reform, I thought this was for consumers, but after I listened to all the presenters, I changed my focus. I wish we could get more consumers to speak about this issue.

Ms. Traveler: I have a question concerning consumers and the use of medication. My sister is a consumer and was identified 30 years ago at the age of 20. She had the old medications like Haldol. Clozaril did not work for her. She was able to express that to her therapist and her psychiatrist. During one crisis when she was admitted to St. Luke's Hospital, she was given Tegretol.

What happens when the consumer leaves the hospital to the community clinic? She had a new doctor there and he did not want to follow through on the prescription from the doctor at the hospital. That happens all the time to consumers. They get caught in the battle between different doctors. When you talked about Wisconsin and North Carolina, what was the major reason that those two states implemented their system of care and why is it working?

Dr. Bach-y-Rita: In Wisconsin in the early 90's, they had the same sort of problem we had and they did something about it. They were spending an enormous amount of money on people going into the hospital. People would come out and say I'm not sick, then not take medications. They'd end up not able to care for themselves, go round and round in and out of the hospital, and go through periods of no treatment. The longer they'd go untreated, the harder that made it when they came back into treatment.

Under the new system, the second time the person came into the hospital, they were taken before the judge. If the judge agreed, they had to remain in a county program for 6 months. If they didn't stay, they sent out someone to pick them up and bring them back into the hospital and get them stabilized again. Then with the savings from lowered inpatient rates, they could provide housing and other programs in the community.

Mr. Fields: The Wisconsin program is a nationally known program. Is the ACT Program or Assertive Community Team. Leonard Stein and Mary Ann Test have published 30-35 articles about it. It's located in Madison Wisconsin. I visited there in the mid 90's. They've dropped a lot of the involuntary part of the treatment. It's also important to remember that Madison is a very different population than San Francisco or California. They have a huge Skilled Nursing Facility where people are locked up. One place that did replicate it is North Carolina. I have a collection of studies on involuntary outpatient treatment, which I'd be glad to share with you.

What's interesting about the studies is that they found no difference between people committed involuntarily to the ACT vs. those who were attending on a voluntary basis. The studies concluded that it was the service richness that created the engagement with the clients and the results. There was no difference between the results for the voluntary and involuntary clients.

Mr. Villalba: Don't we run 4 ACT's? Ms. Ruffin: Yes, and they are voluntary programs. They enroll people who were in out-of-county locked facilities and people with a high rate of hospitalization. My feeling is that they are being very successful, and they are voluntary. But that's not to say that there aren't people who refuse treatment.

Mr. Fields: In San Francisco, Conard and Progress were doing assertive case management 20 years ago. We didn't give it the ACT name, but that's what we were doing. But now our clients are facing serious problems of housing and surviving economically in the system.

Mr. Veverka: I wanted to respond to something about Consumer participation. If you want participation, please don't expect people to show up at night in this building. There are hundreds, even thousands of consumers who will not come to meetings. My son is an example, and his point of view is not represented here. Go out to where they are. Don't expect them to come here.

Ms. Harrison: I run a crisis center and I have clients who are dealing with mental health issues. Ever since the LPS Forum in the Library in November, I've been engaging my clients in discussion about AB 1028. Half of them don't understand it and don't have enough information. My suggestion is that we come up with innovative ways to reach those consumers, and educate them. I think it's important we get more information from consumers, before we make a final decision.

Ms. Deger: While I appreciate the need for further education, we are a Board representing different constituencies and we are supposed to arrive at this table prepared to represent our constituents.

In discussing how the system works or doesn't and what states do what, we've lost track of why this bill was written. It was written for the people who are the neediest. What do the neediest of our constituents need? They need help. I'm disappointed we're not talking about the people who we step over, people on the street. I work at 10 United Nations Plaza, and I don't know how many of you see as many people as I do who are living on the streets.

There was a man in front of my building who was barefoot. I went and bought him shoes. He said, "I can only wear shoes on Mondays. " In a situation like this, are we talking about someone who can make his own decisions? We can make the academic argument, but this is not someone who has made a choice. If it were grandpa on the street with Alzheimer's, we wouldn't hesitate to step in.

Ms. Traveler to Mr. Veverka: Has it been your experience with your son, that he had other medications in the past that did not work. Mr. Veverka: He has crashed on other medications, sure. Ms. Traveler: Over the years they get build ups to the medication. At the end of a certain period of time a medication that has worked before stops working and then the consumer has to convince her doctor that it's not working.

Mr. Dias: I have a friend who is schizophrenic, who has run away a lot, and he's finally in a Board & Care situation that he doesn't like. He's convinced the system has tried to poison him with medication, because he's had such terrible side effects with the medication he's been given. Now he's only on Prolixin.

Dr. Beauford: I do understand everyone's position and this is an extremely sensitive issue. It's similar to 3 strikes and abortion. People's emotions come very raw. I want to echo Renee's position that our role is advocacy. I doubt that we will arrive at a definitive stance at the end. I would appreciate receiving Steve Fields' information and information from anyone else who wants to submit it.

Dr. Moses: We have the right to ask questions and request input from consumers. Most of them do not understand what this bill looks like, but it's important to hear from them.

Mr. Jonasson: I am a consumer; I am a bipolar one. Unfortunately I wasn't diagnosed until my illness had progressed for 10 years and my life was hell. Now I'm on Lithium. I have a tremor, and side effects can include damage to my kidneys. So later there will be other drugs they will switch me to. But without medication I will kill myself within one year. I take my medication every day without fail. I take it despite the side effects because of how important it is to me. I'm aware enough and can understand the doctor and the PDR and can make the decision. But if someone is not aware enough and cannot make a sound decision for himself, then someone else needs to make that decision until he can make the decision for himself.

I do agree that one of the most important things is your relationship with your clinician. And in the whole spectrum of social rehabilitation there 's nothing like a good girl friend.

Mr. Crew: There are a lot of people who feel like Jim does. We need to understand when a decision needs to be made for a client. But it's also important to work with clients before a crisis episode begins and to put in place what they would like to have happen at that time. This is the idea of the advance directives.

I was struck with schizophrenia at age 16, and mine was a very severe illness. I was digging in trash cans trying to find wood to burn so I could stay warm. I didn't have a family to help me out. When mental illness struck it wiped out the basic socialization skills that I should have been learning in my teen years. Too many programs don't teach the socialization skills.

And we need to focus on people that are not white males. For example, African Americans will get two to three times the medications as whites and will still get incarcerated at far higher rates. Another example, why are Asians who need less medication still given the same medication dose as white males? And why are meds still tested only on white males?

People who are gay, lesbian, transgender, and questioning need to think about this LPS issue from a cultural perspective, and we need to educate consumers. I've never heard a consumer say, "I'm not sick." They say, "I'm not crazy." I've not heard a consumer say they will not take medications. But they will tell you about all the medications they have taken that didn't work or they had a bad reaction to. We should be training clients ahead of time to make a wise decision.

Mr. Jonasson: I want to compliment Roy for about 30 seconds which is not nearly enough. Roy's organization is the Office of Self Help. I'm a big believer in social rehabilitation for people on their way back up. People at his center can learn this. It may take years, but unless this is done they may have no life at all.

Mr. Villalba: I'd like to thank all of the presenters. This has been most helpful. As Jim (Beauford) said, it's a delicate issue. I can identify with so many pieces. Jim (Jonasson), you said you hadn't had a lot of talk therapy, but you have done a lot of working through of your illness. How did you get there?

Mr. Jonasson: It was February and I was sleeping outside in Mill Valley, eating out of garbage cans. I decided to give psych one more chance. I walked into Langley Porter and got help. If you have to be mentally ill, bipolar is the way to go. I'm thankful for the difference the Lithium has made.

Mr. Bernick: I'm Jonathan Bernick, Executive Director of Baker Places. I've been in this system for 20 years. We run programs that take people out of the hospital and into an apartment or peer setting. We were founded on the belief that people need to be treated in a dignified way, and that autonomy is a key factor in them being able to adapt to the world.

I'm very concerned about several things that are untruths that were said here tonight. The statistic on the number of homeless mentally ill is around 30% not 70%. What we are talking about is homelessness, and that's a social problem and financial problem. The number of people on the streets is not about mental illness. It's because there is no room in the inn. There's certainly no place for people to go to once they leave treatment in this housing market.

It's important that we not talk about the illness as defining the person, rather than being a disease that a person has.

The most sophisticated and sensible system I've seen anywhere is the system we have in San Francisco. There is no place in the country to compare with the number of residential services we have here. Baker Place alone has 12-13 programs. We move people into voluntary treatment programs to avoid hospitalization. People come to us on a voluntary basis and we never have enough beds. There just are not enough places for people to go. The current 5150 laws would be adequate for many of the people being talked about.

Mr. Dias: The laws are adequate now.

Mr. Shipley: Toye has asked to hear from consumers. I am a consumer. I represent at the state and local level a number of consumers, consumers who are homeless and not medicated, consumers who are highly functioning. There are a couple things I want to say.

There are two sides to this story. Two perspectives, both coming out of fear. Consumers fear that if this passes, it's going to be abused, because that's what happened to them, they've been abused.

Family members are coming to this because they don't know what to do. They don't know how to take care of their family members who are out on the street. Both of those questions are 1) ethical dilemmas and 2) societal dilemmas. We're looking to change the law to try to correct what's happened to this society in the past 30-50 years, without the money being available to provide care to our mental health constituencies. We're coming at this completely backwards, trying to get the lowest funded services in the nation, mental health services, to solve a societal problem. We need to advocate with the legislature for more money, not for LPS reform, but to put more services in place for people who want them.

Ms. Gilleran: I think its a good thing this bill has been postponed in the legislature because it gives us more time to consider it. We can schedule for our next full Board meeting our Board's discussion of what we've heard tonight and our feelings about the proposed changes.

IV. DIRECTOR'S REPORT

Jo Ruffin: I spent the day in Sacramento. As background on LPS Reform, I wanted to let you know that the county mental health association and the State Department of Mental Health have not taken a position on the reform legislation. The legislation was developed outside the state and county mental health systems. There has been a statewide process to gather information, like the Forum we had here in November. I think this is an incredibly complex issue and I want to thank you and the presenters for holding this forum tonight. I think it presented a cross section of the views we are dealing with on this issue.

Separate from the LPS reform proposals at the state level, there has been a recommendation from the Controller's Office to the Government Efficiency Committee of the Board of Supervisors to combine the LPS Conservators Office and the Public Guardian's Office under the Public Guardian's Office. DPH has been considering this and has to make a recommendation to Government Efficiency Committee, chaired by Barbara Kaufman. I won't know what the Department is going to recommend until just before that Committee meets. I think you might want to monitor that hearing.

Right now the LPS mental health Conservator's Office, is supervised under Dr. Katz and is delegated to Larry Meredith who runs our prevention services. It used to be under Mental Health, but it was decided that if Mental Health was providing the services, it couldn't also monitor the commitments. The Office is housed downstairs from us, so we have a close working relationship.

If the Offices are combined they could be combined under the Public Guardian or under DPH or under DHS. I would encourage someone from your Board to stay in touch with this.

Ms. Deger: Didn't they do this in San Diego and a year later they pulled it apart again? Why was that?

Ms. Ruffin: In the majority of counties these offices are combined under mental health or health services. It's as complicated an issue as is the discussion tonight about LPS Reform. The discussion about the Conservator's Office is happening independent of discussions about LPS Reform.

The Budget process does not look good. DPH has been instructed to present a no-growth budget. To not ask for any new money, including contractor's COLAs, is a major problem for Mental Health. Seventy percent of our services are contracted and if the contractors can't meet their payrolls they can't provide the services. It could mean the closure of some programs in order to fund other programs at an adequate level.

The strategy we have is to develop the System of Care as broadly as possible and minimize hospital services. We've been moving in that direction for the last 5 years. We've eliminated Napa beds, we've eliminated locked facility beds, and are using those funds in the community. There's not much more that can be trimmed.

So I will keep you informed. But I'm afraid that once again we will have to get into the process that you've gotten into in the past years, taking an affirmative stance for mental health funding with the Board of Supervisors and the Mayor's Office.

Mr. Shipley: How will this affect the DPH strategic planning process, which is calling for full integration of all services in San Francisco.?

Ms. Ruffin: I don't think it will change the strategy, The issue will be how much you have to integrate. There is a deficit this year at the institutions, particularly San Francisco General Hospital. But the basic strategic planning will continue.

Dr. Moses: Is there any plan to fill the Systems of Care position that is vacant?

Ms. Ruffin: We are planning to recruit someone for that position, but because of the deficit we are in a salary freeze, so we won't be able to do anything until July 1.

Ms. Deger: I'd like to ask the Executive Committee to put meetings with Supervisors on the agenda.

Ms. Harrison: Is LPS implemented the same way for children as for adults?

Ms. Ruffin: There are certain things that don't apply to children in the LPS Act but I'd need to do a little research about that to give you a definitive answer.

Mr. Villalba: I thought our meetings of small groups with the Supervisors worked really well last year. I think we ought to plan strategy once we hear back from Jo and have enough information about the budget, so we can go in small groups to meet with the Supervisors and have a dialogue, hear from them, but have them hear our concerns too.

V. MHB COMMITTEE REPORTS

Executive Committee

Ms. Gilleran: Tonight is a year from the night when we had our memorial meeting for Mary Sue Planck. Certain people, like Mary Sue, strike our lives in indelible ways. She'd be glad to know we're thinking of her, and she'd be gladder still to know we are working so hard on the issues she cared about.

Darwin, I want to commemorate your last evening of your 7 years of service to the Board. (Vigorous round of applause.)

I'm glad to see Brian Peagler back after his extended leave.

Nominating Committee

Dr. Moses: Our election will be held at the February Board meeting. The floor will be open for nominations at that time. The Committee nominations are: Jim Beauford for Chair, Chet Villalba for Vice Chair, and Toye Moses for Secretary.

Also we are proposing the addition of a new office—Chair Emeritus. This would make it possible for the past president to be part of the Executive Committee. We have a Chair who has made good things happen and we don't want her to disappear from the Executive Committee.

Cultural Competency and Special Populations

RESOLUTION (MHB-00-03)
TO SUPPORT SIGNIFICANT FUNDING FOR THE STATEWIDE SUPPORTIVE HOUSING INITIATIVE

WHEREAS, the crisis in affordable housing in San Francisco, in particular, and in California, in general, has for many years had a severe and negative impact on the lives of clients of the public mental health system, and

WHEREAS, supportive housing has been proven again and again to be a humane and effective way to help people suffering from mental illness, especially the homeless mentally ill, and

WHEREAS, San Francisco and other cities in California are in dire need of supportive housing, and

WHEREAS, the State of New York in partnership with New York City has had great success with investing significant funding into supportive housing through the New York/New York program (1990) and the follow-up New York/New York II program (1999), and

WHEREAS, in California, Chapters 310 and 808 of the Statutes of 1998, together created a new program, the Statewide Supportive Housing Initiative, to help local governments and nonprofit organizations pay for the costs of operating and providing services in supportive housing for low-income individuals and for families with children in which the head of the household has one or more chronic conditions including mental illness, a history of alcohol or drug abuse, HIV/AIDS, developmental disabilities, and other health conditions, and

WHEREAS, only $1 million has been allocated for the Initiative to date despite the overwhelming need California is experiencing, now, therefore, be it

RESOLVED that the Mental Health Board of San Francisco recommends in the strongest terms to the City and County of San Francisco that it officially adopt a position of support for the funding of the Statewide Supportive Housing Initiative with at least $20 million per year over the next five years, and instruct the lobbyist for the City and County to strongly advocate for such a level of funding to begin in fiscal year 2000/01. (Passed.)

Dr. Moses to Ms. Gilleran: I wanted to thank you for the leadership you have provided to the Board. You have done wonderfully well.

VI. PUBLIC COMMENT

Questions were asked about the LPS Reform.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:52 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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9/00

MEETING OF THE FULL BOARD

Wednesday, February 9, 2000
1380 Howard, **Room 537**
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A 1. Approval of January Minutes 2. Approval of Leaves of Absence for February	5 minutes
III. ELECTION OF NEW OFFICERS	10 minutes
IV. BYLAWS CHANGE Bylaws change to allow appointment of Chair Emeritus	5 minutes
V. PRESENTATION Presenation by Tangerine Brigham, Director of Policy and Planning for DPH, on Department of Public Health Strategy Update. Afterwards, CMHS staff will present budget plans for the upcoming budget process.	60 minutes
VI. COMMITTEE REPORTS • Executive Committee, Chair's Report • Additional Committee reports as needed	15 minutes
VII. PUBLIC COMMENT PERIOD	10 minutes
VIII. ADJOURNMENT	

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A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

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MENTAL HEALTH BOARD OF SAN FRANCISCO DPH

SEAL OF THE CITY AND COUNTY OF SAN FRANCISCO

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

UNADOPTED MINUTES

Wednesday, February 9, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Jim Beauford, Ph.D. (Chair); Tim Agar; Millicent Bogert representing Supervisor Sue Bierman; Renee Deger; Peggy Gilleran, J.D.; Toye Moses, Ph.D.; Brian Peagler; Gloria Samayoa; Mickey Shipley; Lora Traveler; Chester Villalba; Barbara Williams.

BOARD MEMBERS ON LEAVE: April Martin Chartrand.

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BOARD MEMBERS ABSENT:

PRESENTERS:
Tangerine Brigham, Department of Public Health
Nancy Presson, Community Mental Health Services
Michelle Ruggels, Community Mental Health Services

OTHERS PRESENT: Nancy Presson (CMHS); Mike Wise (Spiritmenders Community Center); Bridgett Brown; Marushka France (Family Member); Marion A. Keller, L.C.S.W.; Stephen Vernon (Family Service Agency); Mark Adamek (San Francisco Network of Mental Health Clients; San Francisco Depressive and Manic Depressive Association); Emeric Kalman (Family Member); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Chair, at 6:40 p.m.

I'd like to make special note that this is the last evening we will have Millicent Bogert with us. We could not have hoped for a better person to be here representing Sue Bierman. Millicent will be moving to a new job at the Controller's Office.

II. CONSENT CALENDAR

RESOLUTION (MHB-00-03): Be it resolved that the minutes of the Mental Health Board meeting of January 12, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-04): Be it resolved that the Mental Health Board grant leaves of absence for the February 9, 2000, meeting to: April Martin Chartrand. (Passed)

III. ELECTION OF NEW OFFICERS

Ms. Gilleran: At our last meeting in January, we announced the following slate for officers:

Jim Beauford for Chair
Chet Villalba for Vice Chair
Dr. Toye Moses for Secretary

Ms. Gilleran then asked for nominations from the floor. There were none.Mr. Agar: I move that we elect all three by acclamation.

All three candidates were then elected unanimously.

Dr. Moses, speaking to Ms. Gilleran: I want to than you for the wonderful job you've done. You have really brought us together.

At this point in the meeting Dr. Beauford took over as Chair and made the following remarks: Peggy has been the consummate Chair person, bringing her wonderful leadership to the Board with a mix of respect. I only hope to be able to do the same. I hope to have the guidance of the Board. I look forward to working with Helynna.

IV. BYLAWS CHANGE

Dr. Beauford: We'd like to make a bylaw change to allow the possibility of a new officer, the Chair Emeritus.

Mr. Shipley brought up the point that this will be a permanent change to the bylaws, but the position will only be filled at the pleasure of the Chair and Executive Committee. Mr. Agar noted that this new position would add a voting seat to the Executive Committee, and asked about the make up and balance of the Executive Committee. Ms. Brooke replied that the Committee consists of the 3 MHB officers, the committee chairs, and one consumer member of the Board appointed to provide balance.

Dr. Moses noted that the new position would help bring continuity from the past Chair to incoming Chair.

RESOLUTION (MHB-00-05)

Be it resolved that the Mental Health Board adds Section 6 to Article V of its Bylaws as follows: "The current Chair in consultation with the Executive Committee, may appoint a past Chair to the office of Chair Emeritus. The term of this office is for one year. The duty of the Chair Emeritus is to serve as a voting member of the Executive Committee, and to carry out other duties as requested by the current Chair and Executive Committee. This is an optional office and may be filled or left vacant at the discretion of the Chair and the Executive Committee." (Passed.)

Dr. Beauford then announced: I'd like to formally appoint Peggy Gilleran as Chair Emeritus. I think you will be a welcome addition to the Executive Committee. I will certainly welcome your tutelage.

V. PRESENTATION: DPH Strategic Planning and Budget

Ms. Presson: I want to take the opportunity to update you on the mental health budget for fiscal year 00/01. The first thing I'm going to pass around is a message from Mitch Katz which was presented at the Health Commission meeting yesterday afternoon.

First, I'd like to summarize the message from Dr. Katz. I don't know if you're aware that the Health Department has had a hiring freeze. So the Department has ceased hiring into vacant positions and this includes Community Mental Health Services. There was a lot of public testimony at the Health Commission yesterday. A lot of the testimony was about the difficult position the Department is in, trying to run programs with over 200 vacancies.

The freeze was imposed because the Health Department is not in line with its budget this year. We had problems last year as well. Most of the problems are with San Francisco General Hospital. And these are not unpredicted problems. There was a reduction of federal dollars for health programs last year and that's happening again this year. So we are in a deficit situation.

The Mayor's budget instructions for this year said that the Departments were to absorb into their base line budgets the anticipated increases in COLA's and MOU's for civil service employees.

Dr. Katz in his comments yesterday, said that if the Department were to produce a status quo budget it would be $40 million in deficit. So there has been a tremendous effort within the Department to try to absorb these costs and to look at our mission and try to be more efficient in how our services are delivered.

In Mental Health, these are things we've been trying to do for years. We've been working to reduce institutional costs and support people living in the community.

The 00/01 DPH budget is moving dollars from one area to another, and including some money for primary prevention. This is the first budget in memory that has $500,000 for prevention programs.

The budget provides funding of a wound program, to treat soft tissue wounds. Many Emergency Room visits are from drug abusers who have infections. These can be managed in outpatient clinics, and where the needle exchanges are taking place. This is budgeted for $1 million.

There is also funding for respite support housing. We know that if you look at who is in our acute psychiatric beds, there are people who could be discharged. They are no longer acute medically, but they have nowhere to go. But they could be served in a hotel with support staff.

There is another group of people who have organic problems like dementia, or problems stemming from alcohol abuse or Huntington's chorea. They have behavioral problems that make it very hard for them to be placed in a skilled nursing facility. The proposed budget assigns $900,000 to these purposes. A hotel in the Mission District will serve these clients.

It's proposed that there be $433,000 for a unit at Laguna Honda specifically for patients from SFGH with neurobehavioral problems. There will be a reduction in the number of beds at SFGH, which is now 30 beds over it's budget.

We are working to keep residential beds. This is a top priority. The City lost funding through the McKinney Grant.

Ms. Ruggels: The HUD funding was reduced and so it did not cover all of our priorities. There will likely be more cuts in the middle of next year.

Ms. Traveler: Is there someone who is in charge of grants for DPH? Ms. Presson: Marc Trotz is in charge of Housing grants for DPH. Ms. Ruggels: The HUD dollars for housing go through the Department of Human Services. We provide the money for supportive services and if there is no housing, there is no place to put the supportive services.

Ms. Presson: The programs affected by the cuts are Ashbury House and Dolores Hotel. And we desperately need all our programs. DPH is making a commitment to save these programs, but it's an additional cost.

In order to fund these programs and deal with our costs, we have done some shifting in mental health that has a negative impact on us. And within the hospital some shifting has been done which has a negative impact on psychiatry.

The single standard of care funding was $1.3 million. That's now been cut to $600,000 . We are in process of awarding the grants based on this money, but the budget being presented to the Health Commission has only $600,000 .

The hiring freeze has affected us and it's unclear when it will be lifted. There are currently 32 clinical positions frozen, and with the proposed shifts, there is the potential to loose 2,000 client episodes.

There is a chance of cutting 21 beds from SFGH. Last year we lost 6. Dr. Katz predicts that as the alternative treatment programs take effect, the number of beds needed will be reduced and there will be the ability to cut 21 more beds. There are currently 84 beds in psych.

Ms. Harrison: Most of what I hear being cut is service, what kind of consideration is being given to cutting administrative costs?.

Ms. Presson: There are administrative positions being cut. There is the intention to unfreeze the frozen positions when the budget is stabilized. Most of the vacancies that have been cut in PHP were administrative positions. The clinical positions are frozen.

Ms. Harrison: If we are in this kind of trouble, maybe we can have one janitor instead of three. Has that kind of dialogue happened?

Ms. Presson: When you are trying to squeeze $40 million out of a budget, you do it every way you can. This budget is not actually balanced. DPH is still asking the City for $18 million. If we don't get that, there will be lay offs in addition to the freeze

Mr. Wise: We're talking about the budget as if we're in the midst of the depression, but the economy is red hot. We go from last year with a big surplus to now with the Election already taken place and Mayor Brown's got a 4-year renewal on his contract. This smells terrible to me. It's like we're in the 30's in the midst of the Depression.

Ms. Ruggels: Like Nancy said, we went into preparing this as a flat budget which means we couldn't ask for new revenues. CMHS is committed to our contract providers, and believe we are a partnership with them. We were planning to provide a COLA, but we don't have the new funding provided to us to do that. So we have tried to set aside funding that will help contractors be able to continue doing business. Still this amount will not cover what the contractors need.

In contract negotiations we will tell the contractors what we can offer and they will come back and tell us what impact that will have on their services. The contractors have been absorbing cuts for so long that they can't do that anymore.

We fund residential care beds in the system. And not all of them are patched. Patched means that CMHS puts in extra money to cover extra costs over SSI. We have 57 residential beds to patch.

We want to annualize the beds for people with organic disorders.

We need to fund a COLA and some increased costs for the IMD's, the locked skilled nursing facilities. This is something we've committed to previously.

We're making fund increases to Inpatient psych. This is to enhance our inpatient budget for our private, fee-for-service hospitals. We want to make sure we don't go into a deficit situation with them.

With regard to salary savings. Let's say we have 100 civil service staff and the cost for them is $1 million. The assumption is that there won't be 100% of the positions filled all year. Currently, we have more staff working than planned, fewer vacancies, so we have a salary saving deficit of $425,000. We've put a plan together to move money from the salary saving line into the real budget so we can spend it.

What doesn't show on the handout, is that PHP has made a commitment to fund housing and prevention. They have sent $150,000 to DPH for lost McKinney money. One additional thing is computer expense, which is something that continues to rise.

We're paying for these changes through reducing expenditures and increasing revenues.

We're lucky in mental health that we have the ability to increase our revenues to offset some of these reductions. We're increasing the Medi-Cal fee for service revenue. We will be receiving an additional $1.1 million in realignment funding

Various of our contractors are able to increase their Medi-Cal expectations. We're increasing our pharmacy Medi-Cal because we've been doing a good job with our billing. With the EPSDT program, we've been generating more than what we've had in the budget. Also patient revenues are up.

Mr. Villalba: What is the total amount of the budget in this system? Ms. Ruggels: Our total budget is roughly $120 million. Of that, perhaps $60 million is outside revenues. $25 million is Short Doyle funding. Medi-Cal is about $30 million. State dollars come to about $50 million. So it's about $148 million for mental health. This doesn't include the Dept. of Psychiatry at SFGH.

Mr. Shipley: What impact has the Governor's budget had? Ms. Presson: The state increased rates for the first time in something like 15 years, but they didn't give us any more money for our Mental Health Plan. The place it impacted us most is in the area of children's services.

Ms. Harrison: You mentioned commitments that were made. Are these commitments being made when there aren't the dollars? Ms. Ruggels: These are commitments we've made before. If we don't keep the commitments, the beds will disappear. Ms. Presson: We're in San Francisco, and the housing costs have increased so dramatically here. We are eroding services by this budget as much as we are trying not to.

Ms. Harrison: Is there anything we can do about salaries? Mr. Shipley: Is this going to freeze raises? Ms. Ruggels: No, that's not possible to do. That's decided at the level of the Mayor's Office, and there are union contracts involved.

Mr. Shipley: You said you're committed to your contractors. Being a MHB member I'm committed to the consumers, which means services, well being, homes, and food that they deserve. I know contractors are there to provide these services. But to me, if they are committed to serving the mental health consumers, the ethical thing to do would be to give up my raise.

Mr. Villalba: Contract employees make significantly less than public employees. If you looked at the contract salaries, they are the most underpaid group in the city after domestic employees and it's pretty disgraceful. Mr. Shipley: I hear that, as long as I'm being heard.

Ms. Presson: I want to acknowledge Michelle who has worked miracles on this budget.

Ms. Brigham: I'm the Director of Policy and Planning for the Department of Public Health. I'd like to talk for a few moments with you about the Strategic Planning process. I want to give you a sense of goals and process. I would be glad to come back another time and to get your input on the specifics of the process.

Ms. Brigham then introduced Dick Hobson, a planner for the Department of Public Health. She handed out a packet of information, then continue with the following remarks: We are currently engaged in a Strategic Planning process. We will be going to various advisory Boards and community groups.

Just today Mickey Shipley, a member of your Board, was appointed our strategic planning process. Marion Keller, who's here in the office, is on the finance committee. Michael Wise, who's also here tonight, has been to some of our town hall meetings.

Funding for health programs is quite precarious, so the Department of Public Health has to plan carefully for the services it wants to provide. It has to plan for demographic changes. We have an aging population. There are changes with regard to the immigrant community and changes with regard to communicable diseases. We want to be able to do long-range planning instead of last-minute planning, with the understanding that there is a limited amount of money for health.

The Health Commission has asked us to start this process of strategic planning. The Director is fully behind this process. We have started in working with the community. We are working on prioritizing where the funding needs to go. We know that we have to prioritize primary prevention and intervention to keep people out of higher cost programs.

Because the Department is really interested in this being a collaborative effort, and there is a larger community in San Francisco very involved in health care, this Strategic Planning process is a long process. We want to have a thoughtful and deliberative process. We started in October of last year and will go through the end of December 2000. We will be having a series of town hall meetings to get consumer input, and get a sense of what the issues are for community providers.

Let me go through some of the slides from the Town Hall meeting part of your packet.

Slide #4: What Services Does the Department Provide?
We provide a range of services not all of which are mandated by the State. The City and County of San Francisco chooses to provide these services on its own and finds other money for it, beside the State funding. DPH is more expansive than many other Health Departments in the state. You might argue that the funds are insufficient as compared to the need, but at the same time it's clear that the City has made a commitment to health.

DPH is trying to take a broader view of health with this planning process. We want to do collaborative planning with other City departments, like the Department of Human Services, the Commission on Aging, Parks and Recreation Department, and the Department of Children, Youth, and Their Families.

Slide #7, Health Trends
Something that concerns us is racial disparities in San Francisco. We have started the African American Health Care Initiative. There may be other groups we'll focus on. We have a newcomers program to help immigrants coming into San Francisco. There are certain populations that are involved in high risk behavior, like teenagers.

When there are a significant number of citizens uninsured and are ineligible for public support then the City and County has to provide those services.

Slide #13, Timeline for Completion

August 3, 1999
Health Commission presentation on the strategic planning needs

August 1999
Formation of Strategic Planning Committee and Sub-Committees

August/September 1999
Strategic Planning Committee and Sub-Committee meet to review purpose and goals of strategic planning.

Late August 1999—October 1999
Strategic Planning Funding Sub-Committee meets to review funding issues, address strategic questions, and develop response.

September 1999—October 2000
Committee and Sub-Committee review assessment findings, address strategic issues, respond to strategic questions, and develop response

November 2, 2000
Health Commission presentation on proposed strategic approach to financing issues for 2000-01.

December 2000
Health Commission presentation on proposed strategic direction

All the information from the sub-committee goes to the Steering Committee appointed by the Director of Health, They will make the final recommendations, which will go to the Director and the Health Commission.

Everything is open right now. There are no recommendations that have been developed. Recommendations will be presented to the Health Commission in December, then the implementation plan will be put into effect, and will probably take place over a multi-year period.

Mr. Kalman: I'm a parent, My son is being taken very good care of by the system. I'd like for you to give a definition of strategic planning. How I know it, it has two components, the planning component, and secondly, how we accomplish what we planned. Also, do you have an inventory of need, of real need in the City. Basically how many people need treatment? How may people were treated? What is the cost in each category? Everything comes back to that dollar sign. Do we have the dollars or don't we have the dollars? We also have the order of selection in California. We have to treat people who have the greatest need. We have to give treatment from the bottom up. Prevention is something that needs more attention. I have a lot of suggestions.

Ms. Brigham: First, strategic planning is an opportunity for any organization to respond to what it sees as external or internal changes and determine where it is currently and where it would like to be in the future. And if you know where you'd like to be, then you can ask how do we get there. So it's the same as your definition.

DPH participates in a variety of needs surveys. There isn't one single comprehensive needs assessment for the entire City, which is what we are trying to do. We are trying to use both qualitative data and also quantitative data. As I said, I'll come back to this group at a later date, and maybe you can bring your suggestions at that point, and I'd like to hear other suggestions.

Ms. Harrison: The strategic planning process sounds great. You said no recommendations had been made yet. But where did Mitch Katz get this idea of closing the Potrero Health Center and selling off the property?

Ms Brigham: The Health Commission adopted a resolution, and directed the Department to identify some of the financing issues, and some of the areas that might need improvement. The Health Commission indicated we'd like to see those principles adopted by the Finance Committee and Steering Committee in the February budget.

Ms. Harrison: I'm really concerned about this health center. Why this one versus another one versus all of them?

Ms. Brigham: This is a hard decision for any Department to make. Potrero is 7 blocks away from San Francisco General Hospital. SFGH has 4 outpatient clinics that provide services to families, women, men, and the general public. Because of that proximity, the proposal is to close the Potrero center and have staff and patients transfer to SFGH.

Ms. Harrison: Did the community hear these wonderful ideas and have input? There were a lot of angry people from the community at the hearing yesterday. Ms. Brigham: We can take your comments back to the Director of DPH and the Director of PHP. Ms. Harrison: I was at the Health Commission yesterday, and I want to thank everyone who was there.

Ms Traveler: I want to thank everyone who made a presentation tonight, because it is complicated material. I'm trying to get a handle on it. I'm hearing that there is a $40 million deficit across the Health Department. And these initiatives are augmentations to the budge that is in deficit. It seems as though there are some things that have already been decided, like selling off the Potrero Hill center for $1.5 million.

Ms. Presson: That's still a proposal, since it is part of the whole budget proposal. Ms. Traveler: What window of opportunity is there for input? Ms. Brigham: There is a Health Commission meeting on the budget next Tuesday. The Mental health Board can also address statements to Mayor, the Health Commission, the Director of the Department of Public Health, and the Board of Supervisors.

Ms. Traveler: What is the timeline? Ms. Brigham: First it has to go the Health Commission. To the Mayor's Office on the 25th of this month. The Mayor's Office then has until May 30th. Then it goes to the Board of Supervisors. Mr. Shipley: That's when the MHB can get involved in meeting with the members of the Board of Supervisors. Ms. Ruggels: and they will have at least one public hearing.

Ms. Gilleran: I'd like to remind us all that Ed Harrington, the Controller, made it very clear to us that things are pretty well set by the time the budget goes to the Board of Supervisors. We need to be involved right now.

Ms. Ruggels: At the Board of Supervisors stage, the budget analysts office tries to find cuts to create a surplus, then some portion of this surplus is given to the Board of Supervisors to do add backs. Ms. Brigham: In terms of dollar value, last year the Board of Supervisors provided add backs of $6 million, of which $2 million came back to the Heath Department.

Ms. Presson: The Health Commission will vote next Tuesday. There is a window right now to influence them. Ms. Harrison: We're asking for next Tuesday, for all of us who know consumers, please try to encourage them to be at the meeting.

Mr. Villalba: I wonder if this Board needs to plan an approach and a strategy. There are so many cutbacks from the federal and state level, and we have done little advocacy with the state and federal representatives. This is a national problem. We really need to do something as a Board. We need to start now and it needs to be ongoing.

Mr. Shipley: The Board of Supervisors had a special Board meeting today about the budget. They had about 40 some people.

Ms. Traveler: I think it's real important for us as a Board to continue to be an advocate for the consumers. We have to see that the needs of our clients are really the priority, and that cuts are made as far away from them as possible.

Dr. Beauford: As a Board we do have the opportunity to form a sub-committee, to address these issues. If there are any Board members who would be interested in that, please stay after.

Thank you to Tangerine, Nancy, and Michelle.

VI. MHB COMMITTEE REPORTS

Executive Committee

Ms. Gilleran: There are two important things to announce. First, regarding LPS Reform, we're starting a work group to study the language of the proposed bill, AB 1800. Everyone who is interested in being on the work group should contact Helynna or Rich in the next week please. We'll be developing questions for Helen Thomson.

Second, the Consumer/Family Member Task Force has been operating under the Mental Health Board for 9 years. They recently voted to end the CTF and submitted their recommendation to the Executive Committee for their approval. At the last Executive Committee meeting their recommendation was accepted. It served a very good purpose over the last nine years. Another council is being formed through CMHS to address consumer and family member issues.

We've placed a plaque on the wall of this room to commemorate the work of the Task Force:

In Honor of the
Consumer/Family Member Task Force
which met in this room for most of its meetings
from its inception on January 30, 1991
through its final meeting on January 18, 2000.

The Mental Health Board of San Francisco
wishes to acknowledge and applaud the
Consumer/Family Member Task Force
for its remarkable nine-year history
of outstanding achievements.

The Task Force will be fondly remembered
for many, many accomplishments including
the key role it played in
designing and establishing the Office of Self Help,
promoting the employment of consumers
within the mental health system,
and developing a vigorous and enduring movement
of consumer activists in San Francisco.

The Board especially wishes to acknowledge
the convenor and founding members
of the Task Force
for their ambitious vision
and for all their hard work
to make it come true.

Ms. Gilleran continued: This Mental Health Board would like to especially recognize Mike Wise. Over the last two years, you have done everything an individual could do to keep the Task Force alive, and we wanted to recognize you. It is within the past few years that the consumer empowerment movement has really grown, and, Mike, for your part in that we thank you.

Mr. Wise: Right up to the very last night. I was in the minority, I wanted to extend the Task Force. But I don't think the idea of Task Force in concept has to die. As you alluded to, there will probably be a new council for consumers and family members. It really has been my pleasure to work with the Task Force and people like Mickey Shipley and Roy Crew and Carol Patterson, and Bridgett who a was a member for a couple years. We tried, some better than others. We hope we did make a difference. and that's all we can hope for.

VII. PUBLIC COMMENT

Marion Keller: I was impressed with the presentation of the financial problems by the representatives of the Department of Public Health, and I was also impressed with the presentation on the Strategic Plan. But in my mind there is a big disconnect. If the people in Strategic Planning do their work, but then it comes to looking at how to implement their end product. Is this Strategic planning for five minutes for five months or five years down the road? And how does it connect with trying to get the money to do the implementation?

It's also very stress producing. You sense the stress among all the people presenting their reports. Maybe that's just the way things are in our community. Does it have to be that way? Is there anybody who can analyze all these facets and come up with a more effective way to do this planning and to secure the funding to support the recommendations coming out of the Strategic Planning process?

We're living in a period of prosperity. Where is the money? Maybe we should get a policy statement from the Mayor's Office first.

Ms. Harrison: I wanted to give a little feedback. I'm new to the Mental Health Board. Every year we do this budget process. I think the disconnect comes in politics.

Mr. Kalman: The word "Strategic Planning" is a mandate in the City Charter. I'm not clear what this is all about. That's why I asked for the definition.

Mr. Villalba: This is a strategic plan for the Health Department. The City Charter talks about a strategic plan for the whole City.

Mr. Kalman: I think 4 Departments already have strategic planning. I don't know if Mental Health or the Health Department is added to strategic planning, if the result is we will get less money if we are not doing the right thing on time.

Mr. Shipley: The Department of Public Health was charged by the Health Commission to come up with a strategic plan on how to shape the future of the Department for next year and the next five years, I believe. Some of the budget deficits are from the previous public health director over committing herself.

VIII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:37 p.m.

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DPH

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE FULL BOARD
Wednesday, March 8, 2000
1380 Howard, **Room 537**
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A 1. Approval of February Minutes 2. Approval of Leaves of Absence for March	5 minutes
III. PRESENTATION: Department of Public Heatlh Strategic Plan: Input from the Mental Health Board to: Tangerine Brigham, Director of Policy and Planning Dick Hobson, Senior Health Program Planner	45 minutes
IV. REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES	30 minutes
V. REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD	5 minutes
VI. COMMITTEE REPORTS • Executive Committee, Chair's Report Budget Resolution, Attachment B • Additional Committee reports as needed Cultural Competency and Special Populations Committee Resolution for Complete and Accurate Data Collection in the Mental Health System, Attachment C	15 minutes
VII. PUBLIC COMMENT PERIOD	10 minutes
VIII. ADJOURNMENT	

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MENTAL HEALTH BOARD OF SAN FRANCISCO

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
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UNADOPTED MINUTES

Wednesday, March 8, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Jim Beauford, Ph.D. (Chair); Scott Ruble representing Supervisor Sue Bierman; April Martin Chartrand; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Lora Traveler; Chester Villalba.

BOARD MEMBERS ON LEAVE: Tim Agar; Renee Deger; Pat Harrison; Barbara Williams.

BOARD MEMBERS ABSENT: Brian Peagler.

PRESENTERS:
Tangerine Brigham, Director of Planning and Policy, Department of Public Health
Richard Hobson, Senior Health Program Planner, Department of Public Health

OTHERS PRESENT: Jo Ruffin (CMHS); Bridgett Brown; Amelia Truman (Community Advisory Board, Department of Psychiatry, San Francisco General Hospital); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Jim Beauford, Chair, at 6:39 p.m. He then introduced Scott Ruble who will be representing Supervisor Sue Bierman at the Board meetings.

II. CONSENT CALENDAR

The Chair opened the floor to public comment before the vote was taken. No member of the public chose to speak.

RESOLUTION (MHB-00-06): Be it resolved that the minutes of the Mental Health Board meeting of February 9, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-07): Be it resolved that the Mental Health Board grant leaves of absence for the March 8, 2000, meeting to: Tim Agar, Renee Deger, Pat Harrison, Barbara Williams. (Passed)

III. PRESENTATION: Department of Public Health Strategic Plan

Dr. Beauford: Tangerine Brigham has agreed to join us again with a brief summary of the Strategic Plan for DPH. It's really important for us to focus just on the strategies for DPH for 2001/02. Budget questions we'll direct to Jo who will be commenting on them during the Director's Report.

Ms. Brigham: When Richard and I were here last month, we presented to you the framework and overview of the Strategic Planning Initiative, and announced that Mickey Shipley of your Board is on the Steering Committee of the Initiative. We're looking at the services we should provide, given the funding available. We wanted to find out from you, based on our previous presentation, what you see as some of the mental health needs going unadressed which we should take into consideration. We're going to different community-based organizations and advisory boards, and we've held two town halls. We're bringing all this information together. What I'd like to get from you are some of the mental health issues which are not being taken care of. Dick will be recording your comments.

Ms. Gilleran: Young people who reach the age where they are no longer eligible for treatment under SED, enter into a period where they fall into a great gap. The adult treatment programs are not really on target for them. There needs to be programming specifically aimed at the 18-30 age group. Children I knew in the adolescent treatment programs fell away when they were transferred to adult programs. A couple of the ones I knew are now dead. A couple are in prison. Others are in addiction programs. The population in the adult population are generally people these young people can't identify with.

Ms. Traveler: There has been a decrease in the staffing at the treatment centers, especially at the 41st Avenue treatment center. It can be very difficult for the clients to get in contact with the doctor and the doctors, of course, cannot be in three or four places at the same time. They have only two clerks at the Center to take care of everything. Pharmacy issues are a big problem now. If the TAR runs out and you are there trying to get your medication, you have to wait until the form comes in. My sister goes to Walgreens for her medications, and if the TAR is holding things up, the pharmacist who knows her will approve a small amount of meds. There's a new computer system that's about to come on-line in the pharmacies and that may be a hold up.

The other thing that's happening at the adult day treatment centers is the constant changing of therapists. They bring in interns. When a client is in her 50's, her experiences far exceed what that intern can handle. It's a constant turnover, and a constant change, and that needs to be looked at.

Another thing that needs to be looked at is the activities that go on. The clients are not allowed to smoke and they are not allowed to exchange cigarettes. That's ridiculous. There are all kinds of studies out that show how important smoking is to mental health consumers to help them relax.

The other area is lack of organized activities at the day treatment center. My sister, because she is an artist, has offered to teach art, and it's gone nowhere. I think it's really important to look at the services and activities that are going on, they've just stopped.

Ms. Ruffin: The pharmacy issue you're referring to is our new pharmacy benefits contract. The institution of the new program has been delayed to April. We're hoping the new program will address some of the issues that you are talking about, Lora.

Dr. Moses: I attended the Public Health Conference at the end of last year. One reason why some people are discontinuing medication is because the medications cause impotence. The speaker at the seminar was talking about using acupuncture instead of psych medications. I was wondering if we could try that. I think we have some programs that are using that now. I'm wondering if we could expand that, and if we could do a study on the effectiveness. It could be cost effective.

With regard to medication, maybe we can learn a lesson from Kaiser. When you get a prescription, you get a pharmacist to take some time with you to explain the use and the side effects of the medication. I'm not sure if that's happening with Walgreens and Rite Aid. We should look into that.

The other issue I want to raise is diversity. I think we need to promote diversity because it is very healthy. The majority of patients in the City are African American. Are we really providing appropriate services?

Ms Traveler: My sister had gone through quite a problem in relationship to the TAR, and then when the meds were ready, one of the pharmacists personally delivered it from Walgreens because she knew my sister needed it. I believe that was such a wonderful gesture that she did. I think there should be some way to commend these kinds of employees.

At the African American Conference in February, many of the points Toye brought up here were addressed there. One of the speakers, Grad Green was saying the way of interacting with the consumer is so important, and it's important to speak honestly and directly and make sure the dialogue is taking place. These kinds of conferences I think are huge shots in the arm.

Mr. Shipley: There are several different conferences coming up. You might attend those to get information. The Dual Diagnosis conference is coming up.

I'd like to see full integration of services across the system for adults and children and the geriatric population. Our population is getting older. We do have a problem with dual disorders in all the age groups. Children are using drugs and alcohol. Children are in gangs. Some of the older students in high school or the beginnings of college are still into that. I don't know the exact numbers, but being on the Treatment on Demand Council, I know some of the numbers.

We've been talking about full integration. We've been talking about maintaining the quality of life for our mental health consumers. We've looked at how housing raises your self-esteem. Like Maslow's hierarchy of needs illustrates.

For years mental health has been the lowest funded of services. Not just in San Francisco but all across the state and country. We know we have to go for the money, follow the money, and keep pushing for the money. We have to advocate at all levels. From City Hall to the state level and the federal government. The federal government is cutting back on a lot of the funding. We've lost $900,000 from the Ryan White funding, and that's going to severely affect AIDS services.

Mr. Villalba: We need to look at planning strategies differently. Nothing's going to change until new funds come in and funding that has been cut is restored. Until that happens nothing is going to happen locally except in a small range. But we, and the City, need to do something very differently, if there is going to be a significant shift.

I agree with pharmacies being able to talk with clients about their medications. But I believe that is inadequate. I believe it's true that 70% of psych patients who start medications stop them. You can scare consumers into taking medications for the short term, but for the long term you need a relationship. I think we should provide additional staffing in addition to the medication. They need case work services.

If you are in some of the programs, like the SPR's for the high-end users, you get intensive services. But if you are not in the high-end population you don't get the services you need.

I think this is a terrific mental health department, we're lucky to have it, but there are gaps due to lack of funding and positions being left vacant. We need to push for more resources on the state and national level.

We need to get away from crisis funding and crisis thinking. It seems like we're always responding to crisis.

I was at the Westside SPR the other day, and it seems like a good program, but what I heard was that they have to deal with the crises first, and so the clients who are not in crisis are not getting the attention they need.

With the capitation program, there is pressure to get clients out of the hospital before they are really ready, in order to save money.

Ms. Traveler: I think your comments are right on, Chet. I was very pleased to see Tipper Gore on Oprah, and she has gone through a battle with depression. Her comments on the needs of the mentally ill were great. I was just blown away to hear her talk about it. She said this is an area she intends to pursue if she gets into the White House. Money is the problem. We're always in the reactive mode. We need to take strong, positive action.

Ms. Chartrand: Something I find lacking in terms of connected services is domestic violence prevention and violence prevention. There is a violence prevention network in the City, but I feel like they are a stepchild of the City. There aren't a whole lot of funds put into these programs. March is women's history month but nothing is being done to focus on violence prevention. How do we prevent women from being in the shelters in the first place? Also there are issues about older boys not being able to go into shelters with their families. So a lot of women end up back with the batterers because they can't stay in the shelters.

Dr. Beauford: I know one of the other areas several Board members have been concerned about are the day treatment programs. These programs are a wonderful preventive intervention to keep people from going into crisis and into the hospital. Certainly there seems to be a need for an expansion of those services, especially for children and adolescents.

Ms. Brooke: I've been working on a curriculum with the Police Department to help police officers in dealing with people who are in crisis out on the street. The police had given high commendations to the Mobile Crisis Unit and Comprehensive Child Crisis. But there is a need for more of these services. There are many times when the police call Mobile Crisis for consultation and as a consequence the person on the street doesn't need to go into the hospital.

Ms. Brown: I'm a mental health consumer. I think as far as prevention goes, there should be easier access to mental health services, especially for people who have had crisis in their lives and are looking for services.

Ms. Brigham: Let me tell you what we're going to do with all these comments we're collecting. We post all the comments on the Internet, and we'll be giving them to the appropriate subcommittee of the Strategic Planning process.

We will be going back to the community before the Strategic Plan is finalized to get feedback. We're looking for groups that you may want us to go to, so if you know of such groups, please let us know.

Mr. Shipley: The African American Health Initiative group really needs to be listened to. The African American community traditionally has gotten fewer services in the City.

Ms. Brigham: In addition to these meetings, we will be holding more town hall meetings. We held three of them in January and February. We have at least another 7 meetings coming up in different districts of the city. The last series of meetings will be when we go back to people with the proposed plan for feedback.

Ms. Ruffin: I know that members of the Board have also talked a lot about the need for more Jail Psych services. Dr. Moses: Yes, indeed, we need more Jail Psych services.

Mr. Beauford to Ms. Brigham and Mr. Hobson: I appreciate the time you've taken to come to our meetings. I'd like to invite you back again toward the fall of the year to update us on the proposal.

IV. REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES

Ms. Ruffin: This will be my last meeting for 6 months. I'm scheduled for my second hip replacement at the end of March. Even though I'm out of sight, you will not be out of my mind at all. I'm sorry to have to go back out for this surgery. I had hoped this could be delayed, but there is a lot of deterioration in my second hip and the doctor said I couldn't put it off any longer. I've asked Nancy Presson to take over for me at your meetings. I've asked Linda Wang to act as Interim System of Care Director. And I've asked Peter Forster to work with them and to triage issues that arise.

I will be back in October. I'm hoping that toward the end of the recovery period I'll be available via phone or e-mail, but I feel very confident about the administrative staff, that they'll be able to continue with the projects we're working on now.

With regard to the budget, the Health Commission forwarded the budget to the Mayor's Office with $6 million being added to provide back up for community services to respond to the cutting of 21 psychiatric beds at San Francisco General Hospital. The Department's plan is not to move people who are acutely ill either medically or psychiatrically. We will be looking for an appropriate site for intensive case management in the community for clients who are ready to leave the hospital, but who need supportive care. Grad Green is part of that team.

The newspaper reported that the All Star hotel might be the site, but I don't think that will be the final site. It's not clear whether the Department will be receiving the additional $6 million. But I know the Mayor's office will be talking with the Department about this.

The budget implications for us in mental health include the following. We are under a position freeze and we're not able to fill positions because of the budget shortfalls this year. We're hoping that things will be balanced and we can start filling positions by July 1. This freeze is resulting in capacity problems in some clinics. We've tried to have a policy this past year of no waiting lists. We've been trying to do this by using the provider network, if clinics are full. But it has been difficult.

We had to reduce our funding for the Single Standard of Care by 50%. This was the $1.3 million for non-Medi-Cal clients to receive the same care as Medi-Cal clients. There was an extensive planning process in the fall to see if we could do a better job of outreach. We have awarded funding to Swords to Plowshares, Instituto Familiar de la Raza, Oasis, and St. Vincent De Paul. We're going to keep the list of proposals, so if we get some funding restored we can go down that list and award funds.

Barbara Garcia, Director for Population Health and Prevention, is very interested in the integration of services. She's starting a number of initiatives which include mental health. She's starting to have cross division meetings on children and teen services.

CMHS has also developed a Transitional Youth Project covering young people from 16-24 or 26. The Coordinator, who is Linda Velasquez in our office, is working with Children's and Adult Services. Our Transition Youth Conference is coming up at the end of March. We do have plans in the works to get a specialized Board and Care facility for transitional youth. We're hoping that will be open in the next few months.

Children's Services has also gotten a number of grants for juvenile justice initiatives which serve the older adolescents.

Mr. Shipley: The State has required the counties to provide Behavioral Services. Is there money attached to that?

Ms. Ruffin: You'll hear us talking about EPSDT funds, through Medi-Cal. It's through those funds that we are able to do some of these expanded services, such as including substance abuse treatment. EPSDT stands for Early Periodic Screening, Diagnosis, and Treatment.

We're already working on our dual diagnosis issues across mental health and substance abuse services. We've also been working on harm reduction programming. We have a cross-division committee that's working on criminal justice issues. Even though Jail Psych Services are not under CMHS they are in our division within DPH.

We have a new acute diversion unit which we've been trying to get open for some time now. It should be open within the next two weeks. The hospital staff feel very strongly about not losing hospital beds, and we feel very strongly that there have to be really good community resources for people. We need both. It shouldn't be either or.

I had received an inquiry from the Board about one of our sites, the OMI Family Center. It took us three years to find a new site for this program when it was evicted from its former space. They moved into a clinic which is next door to a dialysis center, and there have been some problems with the air quality and waste disposal. The staff have been frustrated. We are trying to clarify the issue and see if we can get it fixed.

Some of the discussion with Tangerine was really painful. Somehow our staff is not keeping you as informed as we need to on the development of the programs. What I thought I would do is take your list and talk with Nancy about bringing some of that information back to you. For example, we do have procedures in place to help clients with the medication issues, and we have information sheets about different medications, and still there are major compliance problems. And Lora I really do want to apologize to you that you didn't have a response back on the issues you raised.

We do have a new pharmacy benefits manager. At some point we might want to have Dr. Forster describe briefly to you what the change is. Especially since you're some of the people who will hear complaints if it's not working.

Ms. Gilleran: This is so perfectly on target. Since the point of what we do is just what you're talking about, maybe we need to find a way to feed information to you about what we're concerned about so you can more directly address these issues.

Mr. Beauford: One way we might be able to address this is through the meetings I, as Chair will be having with you, or whoever is covering for you. And we can pass issues along that way .

Dr. Moses: I'm concerned about the situation with pharmacy services. Do we have a policy with Walgreens that they explain to the consumers what the side effects are? Ms. Ruffin: I would assume so, but I will double check. That should be service that I hope would be provided not only to our consumers but to anybody who gets a prescription. There are many pharmacies in the network. Hopefully people will have the convenience of being able to go wherever they want. We also have pharmacies in a number of our clinics so people who can't handle going to outside pharmacies can get their medications at the clinic.

Mr. Shipley: Perhaps we need a summary from CMHS. Also if there are any grants or programs that need our approval, it's important that we get that information well in advance of the deadline. We need time to study and read these proposals, so we know what's involved.

Mr. Villalba: I wondered in terms of our own information, if we could identify some areas of mental health services that we would like more information or details. I don't think we've done that. It would be interesting to know how a patient comes into the system and gets treatment. I'd also like to know how does the system works with families, and what services there are for families. Perhaps we could identify issues at the next Executive Committee meeting.

Ms. Gilleran: We'll really miss you, Jo. Ms. Ruffin: I thank you all. I really do think you are an extraordinary Board and we're very lucky. I really appreciate your support. Dr. Beauford: It's going to be quite a loss for you to be gone till October. You are irreplaceable. I can't wait for you to get back.

V. REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD

Ms. Brooke: Supervisor Tom Ammiano got $180,000 into the budget last year for the Police Crisis Intervention Project. Caduceus Outreach and Marykate Connor worked for three years to get this happening. Mickey and I are both involved in it. It's slow moving, but it is happening. The Curriculum Committee is actually preparing the training. The police have asked for shorter, more focused trainings. But some of us want to stick with the broader kind of training they have in San Jose where the police go to programs and get to talk with consumers. We want to include a lot of intense role playing so police officers will get a feel for what it's like to be a client or a family member.

Mickey has been coming to the meetings and if other Board members want to get involved you're welcome. We're going to put together a consumer focus groupππ.

Today I went to an AB 1800 work group meeting, which is helping develop the City's stance for that legislation. I believe there needs to be a Board member attending the work group, too. Ms. Gilleran and Ms. Traveler volunteered to be part of this work group.

COMMITTEE REPORTS

Executive Committee

Dr. Beauford opened the discussion on the resolution in Attachment B. Mr. Villalba: I'd like to thank the staff for pulling this together in such a short time. They really worked hard on it, and I thought it was wonderful. Mr. Shipley: I appreciate the staff pulling this together for us. What's written here needed to be said.

Dr. Beauford: I hope all the Board members have had a chance to look at this. This is an extremely important document. This includes items we've talked about over the past year. We've been pretty specific in the resolution. Certainly we couldn't have done it without Helynna and Rich.

The Chair opened the floor to public comment before calling for the vote. No member of the public chose to speak.

RESOLUTION (MHB-00-08)
DECLARING A BUDGET CRISIS

WHEREAS, the Department of Public Health is facing deep cuts to its budget for fiscal year 2000/01, and

WHEREAS, such traditional cuts have a new kind of significance given the changing context in which they are taking place, namely that San Francisco is rapidly becoming one of the wealthiest cities in the world, where rents are skyrocketing and the cost of doing business for service providers is increasing at a rate that is out of control, and

WHEREAS, it is becoming more and more difficult for service providers to attract and retain qualified staff, given the increasing cost of living in San Francisco, and

WHEREAS, the combination of spiraling costs and the proposed cuts are enough not just to diminish successful, long-term programs, but to threaten their existence, and

WHEREAS, treatment and residential programs, once lost, would prove impossible to replace in an equivalent way, and

WHEREAS, the decrease in revenues projected by the Department of Public Health for fiscal year 2000/01 are due largely to events beyond the control of the Department, its service providers, and the people being served by the Department, and

WHEREAS, federal and state government is shifting costs to local government by a remarkable and unprecedented rate of disallowing claims for Medicare and Medi-Cal, and through other cuts to funding for health programs, and

WHEREAS, the housing crisis in San Francisco is related to the medical crisis, in that people who are unable to retain affordable housing are generally unable to stabilize and improve their medical conditions, let alone prevent further deterioration, and

WHEREAS, an extraordinary number of people in our city are uninsured or underinsured, and many private companies are not providing adequate coverage, leaving the public health system to provide services at public expense, and

WHEREAS, Community Mental Health Services, in particular, and the Department of Public Health, in general, have made significant strides forward in the past two years in instituting cost-effectiveness and treatment effectiveness measures, such as the ACCESS line, the Single Point of Responsibility programs, and the increased use of state-of-the-art medications, and that to interrupt that progress in any way would not make good business sense, and

WHEREAS, the Mental Health Board believes that a community has a moral duty to care for those people who are ill, suffering, in trouble, and in need, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community, now therefore,

BE IT RESOLVED, that the Mental Health Board gives its endorsement and support to the Health Commission and the Department of Public Health for their strategic commitment to focusing on prevention, community-based services, and sub-acute services, in order to decrease the need for more expensive emergency services, and now, therefore,

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco urges in the strongest possible terms that the Mayor, the Board of Supervisors, and the Health Commission:

1. Declare a Health Emergency in the City and County of San Francisco, and

2. View this emergency from the larger perspective that the current funding crisis was not created by the Department of Public Health, but by larger political and economic forces, and

3. View this emergency from the larger perspective that San Francisco as a community clearly has the financial capacity to adequately care for those in need, and

4. Honor the economic reality that cutting $40 million or even $15 million from the Health Department Budget will indeed cause a significant reduction in services at a time when people are already being turned away from our system untreated and unserved, and

5. Take whatever steps are necessary to increase City revenues in a fair and progressive manner, closing loopholes and making sure that the City is generating full value on property assessments, licensing fees, and contracts, and now, therefore,

BE IT FURTHER RESOLVED, that the Mental Health Board supports the Health Department's request for an additional $25.6 million from the General Fund, and urges the Mayor, the Board of Supervisors, and the Health Commission do everything in their power to also fund the following critical requests:

1. Restore the cut of $600,000 from the Single Standard of Care for mental health services, given the urgent need for services for the homeless and indigent mentally ill, and

2. Provide a 3% cost of doing business increase for contractors, based on their total budget, so they can continue to survive in the current punishing economic environment of San Francisco, as opposed to asking them to cut back on services in order to provide employees with a much needed cost of living increase, and

3. Retain the Potrero Hill Health Center, both the property and the health care programs offered there, given that the City needs more capacity rather than less, and given that once the City sold this property, it would be impossible to purchase replacement property and reestablish the Health Center in the foreseeable future, and

4. Retain the 22-bed psychiatric inpatient unit at San Francisco General Hospital until genuine replacement beds are created for those patients in lower level settings, given that closing this unit without such replacement beds would likely have a contrary effect, costing the City more than it would save, by displacing sponsored, reimbursed patients, and now, therefore

BE IT FURTHER RESOLVED, the Mental Health Board urges that the Mayor, the Board of Supervisors, and the Health Commission to mobilize all the contacts, persuasiveness and strategic political power available to them to:

1. End the runaway rental increases in San Francisco, which are making housing unaffordable for middle class families and the employees of service providers, as well as the poor, the indigent, and those living on fixed incomes, and

2. Undertake even greater initiatives to create significant additional supportive housing for those in need, and

3. Develop regional responses to problems counties have in common, such as the need for inpatient services for pre-adolescent children, in the face of a series of recent hospital closures, and

4. Take all possible measures to insure that private companies are providing adequate health insurance, so they will not be "dumping" their employees on the public health system for services which the private sector should be covering, and

5. Explore and initiate a dialogue to plan strategies with both federal and state legislatures to ensure adequate health care for all citizens on a national and state basis, as a basic human right and common human need, thereby decreasing the burden on local jurisdictions and local taxpayers, and

6. Continue to support the call for a national plan to end homelessness, so that the larger factors which cause homelessness can be seriously and effectively addressed, and so that every state and municipality will be required to take responsibility for the needs of their homeless citizens, and thus cities such as San Francisco will not have to bear more than their fair share. (Passed.)

Cultural Competency & Special Populations Committee
Mr. Villalba gave some background on the resolution in Attachment C and the proposal by the Lesbian/Gay/Bi/Transgender Data Task Force.

Ms. Traveler moved that the resolution be sent back to Committee as follows:

RESOLUTION (MHB-00-09)
Be it resolved that the Mental Health Board refer the proposed resolution entitled, "Complete and Accurate Data Collection in the Mental Health System," back to the Committee asking them to give more attention to other cultural groups in addition to the lesbian/gay/bi/transgender group. (Passed.)

VII. PUBLIC COMMENT

Ms. Truman: The Community Advisory Board of the Department of Psychiatry at San Francisco General Hospital met last night, and we're part of the contingent that's very concerned about the budget cuts, especially closing one of our inpatient psychiatry units. Our units are developed to meet the needs of different cultural populations. If we close one, will we be able to meet the state mandates for cultural competency? This is a very very acute population. What's going to happen to our patients if these beds are eliminated? We support community programs, but will there be enough for these clients?

VIII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:30 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

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Agend

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MEETING OF THE FULL BOARD

Wednesday, April 12, 2000
1380 Howard, **Room 537**
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A 1. Approval of March Minutes 2. Approval of Leaves of Absence for April	5 minutes
III. **PRESENTATION: Mental Health Board AB 1800, the Lanterman, Petris, Short Act reform, Work Group presentation** The Board member committee to analyze AB 1800 will present its recommendations to the Board for discussion and vote to support or oppose all or parts of the bill, or vote to take no position. (See Attachment B.)	45 minutes
IV. REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES	30 minutes
V. REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD	5 minutes
VI. COMMITTEE REPORTS • Executive Committee, Chair's Report Resolution to urge the federal Health Care Financing Administration to allow California counties to continue providing public mental health services without putting the county contract from the State out to bid. (See Attachment C.) • Additional Committee reports as needed	20 minutes
VII. PUBLIC COMMENT PERIOD	10 minutes
VIII. ADJOURNMENT	

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

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MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

MENTAL HEALTH BOARD
ATTACHMENT A
April 12, 2000

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed.

A. Approve Minutes of Prior Board Meeting

RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of March 8, 2000, be approved as submitted.

B. Approve Requested Leaves of Absence

Additional requests may be added at the Board meeting.

RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 12, 2000, to the following members: none.

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ATTACHMENT B
MENTAL HEALTH BOARD
April 12, 2000

PROPOSED RESOLUTION (MHB-00-xx) REGARDING AB 1800, THE LANTERMAN, PETRIS, SHORT REFORM ACT

WHEREAS, the Lanterman, Petris, Short Act has for 30 years been the legislation which has regulated involuntary commitment and involuntary treatment of people with mental illness in the state of California, and

WHEREAS, certain state legislators are proposing reforms of the Act which would have significant impact in terms of treatment strategy, practice, and cost, as well as significant impact with regard to the civil liberties of people with mental illness, now, therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco urges the City and County of San Francisco to take the following action with regard to AB 1800, the Lanterman, Petris, Short Reform Act, authored by Assembly Member Helen Thomson, and State Senator Don Perata:

choose one:

☐ Support AB 1800 in its entirety.

☐ Support AB 1800, but lobby for the following admendments: *list sections the MHB opposes, and what it proposes as amendments to those sections.*

☐ Oppose AB 1800 unless amended in the following ways: *list sections the MHB opposes, and what it proposes as amendments to those sections.*

☐ Oppose AB 1800 in its entirety.

☐ Take no position on AB 1800.

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Mental Health Board AB 1800 Work Group Committee Observations and Recommendations.

Committee Members: Renee Deger, Mickey Shipley, Peggy Gilleran, Lora Traveler.

There are ten main components of AB 1800. The Committee reviewed each component and the proposed changes. Observations and recommendations follow for Board member review, discussion, and vote at the Mental Health Board meeting on April 12, 2000.

1. The committee reviewed the first proposed change to the definition of gravely disabled, but did not review the amended proposal, therefore the committee does not have a recommendation at this time.

Current Law: Gravely disabled: a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.

The amended change adds: or presents, as a result of mental disorder, an acute risk of physical or psychiatric harm to the person in the absence of treatment.

2. Repeals the capacity hearing following the certification hearing held within 72 hours to determine the patient's capacity to consent or refuse the administration of medication.

Recommendation: The Committee does not recommend repealing the capacity hearing. Consumers are concerned that having only one certification hearing at 72 hours which also includes a capacity hearing does not sufficiently protect against civil rights abuses. It is too much of a one shot deal. Providers are concerned that having to both certify and prove capacity will result in too high a burden of proof resulting in making it more difficult to provide treatment.

3. The current law requires that a certification hearing be held within 72 hours to determine if there is probable cause to believe that a patient is a danger to her/himself, a danger to others, or gravely disable. The proposed change would expand probable cause to include "lack the capacity to make informed decisions regarding his or her own treatment.

Recommendation: The Committee does not suggest this change particularly with the elimination of the second capacity (Riese) hearing.

4. Upon expiration of the 72 hour treatment and evaluation, current law allows a person deemed a danger to her/himself, a danger to others or gravely disabled be held for 14 days of involuntary, intensive treatment if certified by a physician. The proposed change extends this hold to 28 days.

Recommendation: The Committee supports an extension to 28 days, although Mickey expressed concern about Medicaid and medical funding for the additional time because they don't cover beyond the acute care stage. Providers have indicated that most people would not be held much beyond 14 days but having the extension would potentially provide the opportunity for people to become more stable.

5. The proposed change requires that persons committed pursuant to Sections 5150 and 5250 shall be placed in community assisted outpatient treatment programs for 180 days if a hearing officer finds the person sufficiently stable to benefit from community treatment in an appropriate unlocked setting, the person agrees to treatment, the person does not present an immediate harm to self or others, and a community treatment plan is prepared by the multidisciplinary outpatient treatment team and is agreed to by all parties.

Recommendation: The Committee is concerned that the criteria for the extensive multidisciplinary team and the extensive details regarding the treatment plan are good ideas but unrealistic and would ultimately make outpatient placement a non-option.

6. The proposed change repeals the extension of the first 14 day hold to an additional 14 days. This part was already changed in #4 with the proposed extension of the first 14 day hold to 28 days.

Recommendation: The Committee supports this proposed change.

7. Current law post-certification intensive treatment up to 180 days if a person is still deemed a danger to others. AB 1800 proposes an extension to one year.

Recommendation: The Committee is opposed to this change.

8/9. The proposed change lessons the burden of proof requirement to "clear and convincing" evidence from "beyond a reasonable doubt"for the 180-day post-certification and for conservatorship.

Recommendation: As long as safeguards such as patients rights are observed and the person or an advocate for the person is able to make a case for themselves, the committee felt that the lesser burden of proof would be appropriate.

10. AB 1800 allocates $350 million.

Recommendation: The Committee cannot evaluate the cost of increased hospitalization and outpatient care and so cannot determine if this would be sufficient. They support at least $350 million but they are not confident that anything close to this amount would be approved.

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ATTACHMENT C
MENTAL HEALTH BOARD
April 12, 2000

PROPOSED RESOLUTION (MHB-00-xx)
IN SUPPORT OF CALIFORNIA COUNTIES CONTINUING TO PROVIDE MEDI-CAL MENTAL HEALTH SERVICES

WHEREAS, the State of California and its counties have spent the last eight years developing an effective, statewide system of mental health managed care, beginning with Realignment in July 1992, and continuing on with the consolidation of Medi-Cal inpatient services in January 1995 and the consolidation of Medi-Cal outpatient services in April 1998, and

WHEREAS, this single system of care has earned the strong support of the full range of stakeholders in California, including providers, clients of the system, and family members, and specifically including the California Coalition for Mental Health and the California Mental Health Directors Association, and

WHEREAS, there is a possibility that the federal Health Care Financing Administration will propose a major disruption to this statewide system by putting it out for bid in fiscal year 2002/03, thereby creating a double system of care, and

WHEREAS, such a requirement would fragment an already under-funded system, and

WHEREAS, such a requirement would allow private companies to take the most profitable clients off the top, while leaving counties with indigent and safety net responsibilities, but with seriously diminished resources, and

WHEREAS, such a requirement, rather than increasing consumer choice, could very well have the contrary effect of limiting consumer choice, since it is not at all clear that private companies would provide the full range of services currently provided by the counties, and

WHEREAS, such a requirement would not really increase consumer choice unless it mandated that multiple providers split the contract for each county, which arrangement would not be economically feasible and would have the contrary effect of undermining if not destroying existing community-based providers, and

WHEREAS, such a requirement could well have a contrary effect in terms of cost-effectiveness, since a double system of care, one for Medi-Cal clients and another for the indigent, would duplicate services, and would increase administrative costs in terms of transferring people between systems as they go on and off of Medi-Cal, and,

WHEREAS, such a requirement would open up a major crack for clients to fall through between the public Medi-Cal system and the privately-owned Medi-Cal system, and therefore add inefficiencies back into the system that California has spent the past eight years taking out, and

WHEREAS, the coordination of the funding structure at the county level can achieve economies of scale and ensure the survival of essential community providers, now therefore,

BE IT RESOLVED, that the Mental Health Board of San Francisco urges the Health Care Financing Administration to recognize the fundamental intergovernmental relationship between the State of California and its counties with regard to mental health services, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco urges the Health Care Financing Administration to honor and support the intensive work the State of California has been doing over the past eight years in developing its statewide mental health system by not requiring competitive bids for contracts beginning in fiscal year 2002/03, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco urges the City and County of San Francisco to request that the California Legislature pass a joint resolution calling on the Health Care Financing Administration to support California's current system of Medi-Cal mental health services by not requiring competitive bids.

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MENTAL HEALTH BOARD OF SAN FRANCISCO

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UNADOPTED MINUTES

Wednesday, April 12, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Chet Villalba (Acting Chair); Tim Agar; Scott Ruble representing Supervisor Sue Bierman; April Martin Chartrand; Renee Deger; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Lora Traveler; Barbara Williams.

BOARD MEMBERS ON LEAVE: Jim Beauford, Ph.D.; Pat Harrison.

BOARD MEMBERS ABSENT: Brian Peagler.

OTHERS PRESENT: Nancy Presson (CMHS Interim Director); Emeric Kalman, Marion Keller; Bridgett Brown; Marushka France; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Chet Villalba, Acting Chair, at 6:43 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-00-10): Be it resolved that the minutes of the Mental Health Board meeting of March 8, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-11): Be it resolved that the Mental Health Board grant a leave of absence for the April 12, 2000, meeting to: Jim E. Beauford, Ph.D. (Passed)

III. PRESENTATION AND DISCUSSION: AB 1800 and the Reform of the Lanterman Petris Short Act

Mr. Villalba Introduced Colleen Johnson, Senior Legislative Planner for the Department of Public Health, who was present to provide technical assistance on the most current version of the legislation as needed. Ms. Deger as Chair of the MHB Work Group chaired the discussion.

Ms. Traveler: AB 1800 is the first really major change in the LPS Act in over 30 years. It presents sweeping changes, and we're going to go into those points, but I think it's important for us to understand that there are changes in the definition of "gravely disabled."

Ms. Deger: The regional chapters of NAMI met for 5-6 Saturdays in a row and picked through the bill and had some significant problems with the bill, and came up with recommendations. The Work Group looked at that work, plus consumer perspectives and the points we got from the DPH Work Group. We came up with a list of things we didn't like about the bill, and what we thought it should say.

Mr. Shipley: I got on the Work Group as an MHB member, but brought a consumer perspective to discussion since I am on the regional Board of the California Network of Mental Health Clients and the CAARES Council.

Highlights of the discussion and Work Group recommendations include the following:

AB 1800 combines the capacity hearing and the certification hearing into one. The MHB Work Group's recommendation was the following: The Committee does not recommend repealing the capacity hearing. Consumers are concerned that having only one certification hearing at 72 hours which also includes a capacity hearing does not sufficiently protect against civil rights abuses. It is too much of a one shot deal. Providers are concerned that having to both certify and prove capacity will result in too high a burden of proof resulting in making it more difficult to provide treatment.

AB 1800 extends the 14-day hold to 28 days. The Work Group recommended the following: We support an extension to 28 days, although Mickey expressed concern about Medicaid and Medi-Cal funding for the additional time because they don't cover beyond the acute care stage. Providers have indicated that most people would not be held much beyond 14 days, but having the extension would potentially provide the opportunity for people to become more stable.

The system has a policy of keeping inpatient stays as short as possible, and most people stabilize within 14 days, so the extension of the 14-day hold to 28 days, will basically mean cutting out the extra procedural steps.

AB 1800 requires that persons committed pursuant to Sections 5150 and 5250 shall be placed in community assisted outpatient treatment programs for 180 days if a hearing officer finds the person sufficiently stable to benefit from community treatment in an appropriate unlocked setting, the person agrees to treatment, the person does not present an immediate harm to self or others, and a community treatment plan is prepared by the multi-disciplinary outpatient treatment team and is agreed to by all parties.

The Work Group recommended the following: We are concerned that the criteria for the extensive multi-disciplinary team and the extensive details regarding the treatment plan are good ideas, but unrealistic and would ultimately make outpatient placement a non-option.

The cost of putting the team together that the legislation requires would be prohibitive, especially under current budget conditions.

Could this actually come to exist? It's a fantastic list. The Work Group felt it was too detailed for legislation.

This language could keep people in inpatient treatment longer than necessary, for example, if you don't have the multi-disciplinary team required by the law or not enough of them to meet the need. A person might be required to stay in the hospital extra days until the team could get around to him or her.

The language could say, "may include" instead of "will include."

Related to this is the issue of re-commitment. If someone is noncompliant they can be re-committed for the full term of their original commitment. What do you do when someone is re-committed but does not meet the requirement of being acute?

In terms of placement in community outpatient assisted treatment, one of factors is that treatment is available, and that requirement has been removed from the bill.

When they closed the state hospitals, community-based care was to have a full range of components, and it's been implemented haphazardly in some counties. San Francisco has done better than others, but if you don't legislate the range of treatment, it won't happen. There is the question of where the money is coming from, of course, but there is value in having the law state what people need for good care.

Some of the language in the list makes the requirement impossible to fulfill. The language needs to be made more specific. Unless we make language that is specific and precise and then enforce it, it has no meaning. We found throughout the bill a pervasive sort of vagueness, and if the bill were to be passed, it would likely be subject to challenge in the higher courts.

Once thing of concern about this part of the bill is that it ties the team to inpatient treatment. We should be wrapping the services around the person in the community to prevent the them from having to go into the hospital. You can tell when someone is in need.

All this reflects after-the-fact strategies, and that's troubling. Could there be a prevention piece as part of this bill? From a consumer point of view that would be better.

What's so odd about the bill is an expansion of a civil commitment, but in CMHS we've developed our services as alternatives to involuntary treatment. It's almost that an over-arching statement needs to be made. We understand that out of concern for public safety we may have to look at civil commitment again. But it's the linking of civil commitment to treatment that I have trouble with.

We should make it possible to do assertive community teams, but we don't want it necessarily tied to the hospital. Right now the current length of stay in San Francisco is about 9 days. These teams may in fact prolong the hospital stay. And the bill may limit the ability to design a treatment team that is appropriate to client's desires and needs.

The DPH Work Group is linking AB 1800 to other legislation like AB 34, which funded wrap around services in 3 counties. These services have proven successful even just since implementation in October. It's important to have community resources at the outset. AB 1800 is a backwards approach.

AB 1800 extends the 180-day hold to one year if you are a danger to others. The Work Group is opposed to this change. We felt it was an awful long time.

I believe these two legislators, Thomson and Perata, are reacting to media. The media always want to put the mentally ill in the frame of being maniacs. This is a knee-jerk reaction. It's response to those types of media items, which gather all kinds of momentum in our country.

AB 1800 lessens the burden of proof requirement to "clear and convincing" from "beyond a reasonable doubt" for the 180-day post-certification and for conservatorship. The Work Group recommendation was: As long as safeguards such as patients rights are observed and the person (or an advocate for the person) is able to make a case for themselves, the Work Group feels that the lesser burden of proof would be acceptable.

We all know people for whom this law is not working and an altered burden of proof would help, as long as the mechanisms in place now to protect patients rights continue to be in place.

Beyond a reasonable doubt is the criminal burden of proof. There is a concern about mixing civil and criminal issues here.

It's not a concern about the standard of proof. It's about the amount of liberty lost. A person in a treatment facility has lost a great portion of his liberty, and therefore the high standard is not offensive.

Since there are only 35 Napa slots available to San Francisco, the DPH Work Group questioned where we would put people like this. The way the San Francisco system works is more progressive than other places in the state. We work out plans that don't keep people for the full 180 days.

AB 1800 states that there would be $350 million appropriated under this legislation and that up to 25% of a county's portion of the funding could be used for inpatient services. The Work Group's recommendation was: The Work Group cannot evaluate the cost of increased hospitalization and outpatient care and so cannot determine if this would be sufficient funding. We support at least $350 million but we are not confident that anything close to this amount would be approved.

We need to add: The MHB strongly urges the State to use more clear and specific language. We want to see this legislation incorporate community-based prevention, intervention, and treatment options, and encourage access to community intensive treatment without going through inpatient services first.

Under the legislation, Counties would submit information to the State Department of Mental Health and the Department would report on the effectiveness of the bill. This is a good component because right now there is no uniformity on how LPS is implemented statewide. It's pretty much a free for all.

Public Comment on AB 1800

Marion Keller: Point #1 about the definition of gravely disable is that a person is unable to provide for his or her basic needs. In the County of San Francisco the psychiatric judge at a hearing on conservator ship interprets this term by looking at the patient who is present at the hearing. If that patient is dressed well, the judge determines that this person is able to provide for their own needs, and doesn't ask who provided the clothing and whether someone else has made the person look good, but actually the person can't provide for themselves. This has come up many times over the years. That's the sticking point. Different conservators have told me, as long as the person looks good, the judge determines that that person can provide for themselves. I think the definition of gravely disabled needs to be expanded. Those words are simply inadequate and not enough.

Ms. Johnson: Currently there is language in the law that says a person cannot be deemed gravely disabled if they are being cared for by family friends, or others. The Court is probably presuming that the family is providing. This bill requires that the family agrees to meet medical and psychiatric needs as well.

Ms. France: On point #5, what about adding more realistic and flexible options for a treatment plan with the agreement of the consumer? On the burden of proof issue, how does an advocate for the individual know how to access this process? Is it through Patient's Rights coming in and assisting?

Mr. Kalman: I want to expand the previous speaker's observation about Point #1. I think the most important component is medical treatment and that should be the first priority.

Ms. Brown: I have a problem with the 28-day hold, as a person with a psychiatric disability, I think there are already things in place for people who need to stay longer. I don't see how this bill can be effective, and they are already talking about cutting psychiatric beds at San Francisco General Hospital.

RESOLUTION (MHB-00-12)
REGARDING AB 1800, THE LANTERMAN, PETRIS, SHORT REFORM ACT

WHEREAS, the Lanterman, Petris, Short Act has for 30 years been the legislation which has regulated involuntary commitment and involuntary treatment of people with mental illness in the state of California, and

WHEREAS, certain state legislators are proposing reforms of the Act which would have significant impact in terms of treatment strategy, practice, and cost, as well

as significant impact with regard to the civil liberties of people with mental illness, now, therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco urges the City and County of San Francisco to take the following position:

Support AB 1800 (Thomson), but only if the following conditions are met:

That there be an extensive refinement of the legislation to establish more specific lanaguage so that implementation of the bill will not produce contrary effects.

That there be included in the bill provisions for community-based prevention, intervention and treatment options, and to encourage access to intensive case management and treatment in the community without going through inpatient services first.

That the capacity hearing and the certification hearing not be combined, since there is a clear need for both hearings in order to protect against civil rights abuses and in order to make it more possible to provide appropriate treatment.

That the provisions regarding the multi-disciplinary team tied to hospital treatment be removed, since these provisions are unrealistic and since this reverses the current successful strategy of using intensive case management teams to prevent hospitalization and involuntary treatment.

That post-certification intensive treatment be kept at 180 days and not extended to a full year.

That adequate funding be provided for implementation of the final version of the legislation, without sacrificing or diminishing community-based, voluntary services. (Passed.)

IV. REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES

Ms. Presson: I spoke with Jo Ruffin yesterday. It's now two weeks after her second hip replacement surgery. She' doing very well. This hip is going much better than her other one.

The Budget is in the Mayor's Office. There are grave concerns being expressed about the loss of psychiatric beds at San Francisco General Hospital. The Board of Supervisors is very interested in following this. But it's not clear that anything will change.

The proposed Budget cut $3 million, closed 21 beds, and offers $900,000 for community alternatives. Specifically this would be a hotel with support services. It's unlikely that the hotel project could come on board until after January 2001.

Progress House has opened a new Acute Diversion Unit, and these are the first new crisis beds in 15 years. We have a commitment that these beds are solely for diversion. Progress will have a full time person in Psychiatric Emergency Services working with our staff and our clinics to divert people who are teetering on verge of hospitalization. We are very committed to this and will keep you updated. The unit is located on 7th Avenue between Irving and Judah. Progress rebuilt the building from ground up. It has 12 beds.

As part of Jo Ruffin being away, Barbara Garcia has requested a 6-month plan for CMHS. I wanted to share the top priorities on our plan. We plan to continue to reduce unnecessary institutional days. The new ADU will help with that. We are planning programs and what else we can do. We are working hard to assist people who are ready to return to the community to make the return. Sometimes that's pretty complicated. Can't create a facility for each person, but try to plan what's going to work best for each individual.

The average hospital stay across our system is 9 days. The private hospitals have a lower average. The average at San Francisco General Hospital has been about 18 days, and that's been greatly affected by a number of people who are almost impossible to place.

Looking at the children's system, in order to get people out of the hospital faster we've established a new linkage team. Some of the hospitalization that's happening is because of changes in the law making it almost impossible to place children out of state. There's a shortage of group homes, so some children go to the hospital instead. We're creating an expansion of the Seneca Program, located in Mental Health Rehabilitation Facility. There are 12 beds in the open section there and we're developing another 10 beds. It will be one of the first locked children's units.

We're looking at opportunities to get additional funding for mental health. We will come to you about our SAMSHA grant next month. That money will not increase, but we're looking forward to new grant funds that are being made available.

We've been in a hiring freeze that has crippled our clinics. It's affected our capacity to take in new clients. We've been told that we can probably expect to start hiring again in July.

Ms. Brooke: A position was defunded in Mobile Crisis for a year. They are tightly constrained anyway, so they will not be able to answer as many calls.

Ms. Williams: My understanding is that there were 7 positions that were going to be eliminated. Ms. Presson: We've had so many shortages in DPH. When a new grant position is funded and the staff is recruited from within, the civil service position they leave is then defunded, creating holes in our system.

Mr. Shipley: The County Ombudsperson hasn't been hired. Ms. Presson: That's a position that will be open in July.

Ms. Presson: We're working on trying to improve access to mental heath services under the Single Standard of Care. We awarded contracts this past week to: Swords to Plowshares, the Shelter at St. Vincent's, Community Vocational Enterprises, Instituto Familiar, the Study Center's peer support program at Oasis. But we did lose half of the funding that was allocated last year to balance the budget for the coming year.

Sai-Ling Chan-Sew has established a new Parent Support line which is connected with our Access line.

Our State audit went very well. There was one minor finding having to do with contract language. Another finding was significant, and had to do with answering the phone line in the evening, especially with regard to language issues. We will be working with Suicide Prevention on increasing their training.

Ms. Traveler: I'm a little confused on problems with money. We've got a new ADU but we're closing 21 beds at SFGH. Where's the money coming from for the ADU and the new children's beds?

Ms. Presson: The ADU has been in planning for 3 years. One of our principles is that we move institutional dollars to community alternatives. That money has been set aside. With regard to the Seneca Program, we had always been planning to have these beds as part of the MHRF. Twenty-two beds were originally assigned to adolescents. When the MHRF was ready to open, it still was not legal for children to be locked in community facilities. This has been in process for a long time. What we never planned for is SFGH's loss of revenue and budget problems, SFGH and Laguna Honda have both been having significant budget problems. Because of that, in order to stay at the same level of service in DPH, there would be a need for an additional $40 million.

Ms. Traveler: Is there some grant money earmarked for the study of the needs of the African American community? Ms. Presson: CMHS is part of the African American Health Project. Tina Yee and Ladonnis Elston from our office are working on that. I don't know the specific amount of funding. But the need for the project has been identified by CMHS over the years, especially given the number of African American children in our system and the number of African American adults who are 5150'd.

V. REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD

Helynna Brooke: The Police Crisis Intervention Project is developing the curriculum for helping police interact with the mentally ill. Mike Cowhig from the San Francisco Police Department went to the police crisis intervention training in San Jose and was extremely impressed. In the past months, the plan had shifted to training small groups of officers, but we are now going back to the original plan to do the intensive training with large groups of police. Otherwise, by my calculations, it would take 23 years to train the whole Department.

We're writing the Annual Report currently. We're focusing on the positives, on the successes our system is having, and out of that come recommendations for building on those successes. We're featuring ten programs and their directors. These programs have been doing really well for the consumers they serve, and are led by dynamic, creative directors.

On Thursday, May 25th from 4-6 p.m., the Board will hold a Reception for the Mayor, the Supervisors and their staff, the 10 program directors we;re featuring, and of course, our own Board members. The Reception will take place in Mayor's Conference Room at City Hall. We will be honoring John Burton. This will be a great opportunity for our City leaders to get to know the directors of some of our best programs and hopefully they'll be inspired to increase support for mental health services.

VI. COMMITTEE REPORTS

Executive Committee

RESOLUTION (MHB-00-13)
IN SUPPORT OF CALIFORNIA COUNTIES CONTINUING TO PROVIDE MEDI-CAL MENTAL HEALTH SERVICES

WHEREAS, the State of California and its counties have spent the last eight years developing an effective, statewide system of mental health managed care, beginning with Realignment in July 1992, and continuing on with the consolidation of Medi-Cal inpatient services in January 1995 and the consolidation of Medi-Cal outpatient services in April 1998, and

WHEREAS, this single system of care has earned the strong support of the full range of stakeholders in California, including providers, clients of the system, and family members, and specifically including the California Coalition for Mental Health and the California Mental Health Directors Association, and

WHEREAS, there is a possibility that the federal Health Care Financing Administration will propose a major disruption to this statewide system by putting it out for bid in fiscal year 2002/03, thereby creating a double system of care, and

WHEREAS, such a requirement would fragment an already under-funded system, and

WHEREAS, such a requirement would allow private companies to take the most profitable clients off the top, while leaving counties with indigent and safety net responsibilities, but with seriously diminished resources, and

WHEREAS, such a requirement, rather than increasing consumer choice, could very well have the contrary effect of limiting consumer choice, since it is not at all clear that private companies would provide the full range of services currently provided by the counties, and

WHEREAS, such a requirement would not really increase consumer choice unless it mandated that multiple providers split the contract for each county, which arrangement would not be economically feasible and would have the contrary effect of undermining if not destroying existing community-based providers, and

WHEREAS, such a requirement could well have a contrary effect in terms of cost-effectiveness, since a double system of care, one for Medi-Cal clients and another for the indigent, would duplicate services, and would increase administrative costs in terms of transferring people between systems as they go on and off of Medi-Cal, and,

WHEREAS, such a requirement would open up a major crack for clients to fall through between the public Medi-Cal system and the privately-owned Medi-Cal system, and therefore add inefficiencies back into the system that California has spent the past eight years taking out, and

WHEREAS, the coordination of the funding structure at the county level can achieve economies of scale and ensure the survival of essential community providers, now therefore,

BE IT RESOLVED, that the Mental Health Board of San Francisco urges the Health Care Financing Administration to recognize the fundamental intergovernmental relationship between the State of California and its counties with regard to mental health services, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco urges the Health Care Financing Administration to honor and support the intensive work the State of California has been doing over the past eight years in developing its statewide mental health system by not requiring competitive bids for contracts beginning in fiscal year 2002/03, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco urges the City and County of San Francisco to request that the California Legislature pass a joint resolution calling on the Health Care Financing Administration to support California's current system of Medi-Cal mental health services by not requiring competitive bids.
(Passed.)

Mr. Villalba announced that last week Mickey Shipley had celebrated his 18th year of sobriety. There was a vigorous and enthusiastic round of applause.

Mr. Shipley: I know I wouldn't have made it without the support of the fellow upstairs and the help of the support systems I've been part of. I want to hand the congratulations back to Substance Abuse Services, Community Mental Health Services, and all the organizations and schools that have made the difference in my life.

Ms. Chartrand: I was admitted into San Francisco General for surgery on March 17th. Prior to my arrival at the hospital, the care I received was perfect, but in the hospital there were health and safety violations, and civil rights violations. I will be making a presentation to Health Commission on Tuesday and have sent a letter of complaint to Mitch Katz, the Mayor's Office, and the system of care.

VI. PUBLIC COMMENT

Mr. Kalman: I have an issue. Dr. Mitch Katz disclosed in the press that he will put more money in prevention than in acute hospitalization. Do we have any prevention programs? Or a strategic plan for prevention?

Ms. Presson: Our Division's budget this year includes some initiatives that moved money out of high-end services into community services. Some of this was to pay for housing where grants had been lost and the housing would have disappeared without that transfer. There were some funds put into prevention programs. I think Dr. Katz's intention is to see movement from institutional care to community care over time.

Mr. Kalman: Why I'm raising this issue is that for the past 4 years, the budget for prevention has been practically eliminated. Any dollars added for prevention will save us a thousand times more. Ms. Presson: I can give you Larry Meredith's phone number. He's the Director of Prevention programs in DPH. He could give you the background information.

Ms. Keller: I'm on the Finance Subcommittee of the DPH Strategic Planning Committee. We had a meeting this afternoon. I raised that specific question about prevention. There are two kinds of prevention, injury and illness. Each requires a specific kind of program. I see a big disconnect between what the people on the committees are doing and the anticipated end results. I'd be happy if somebody could present to me or anybody where is this connection. But community participation isn't happening.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:42 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE FULL BOARD

Wednesday, May 10, 2000
1380 Howard, Room 537
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS 5 minutes

II. CONSENT CALENDAR See Attachment A 5 minutes

1. Approval of April Minutes
2. Approval of Leaves of Absence for May

III. THE ART OF ADVOCACY 45 minutes

Deedee Jenson will facilitate a Board training on how to effectively advocate for change with elected officials.

IV. REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES 30 minutes

V, REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD 5 minutes

VI. COMMITTEE REPORTS 20 minutes

- Executive Committee, Chair's Report
- Cultural Competency & Special Populations Committee
  Resolution to endorse the Lesbian/Gay/Bi/Transgender Data Task Force proposal to improve data collection in the mental health system.
  (See Attachment B)
- Additional Committee reports as needed

VII. PUBLIC COMMENT PERIOD 10 minutes

VIII. ADJOURNMENT

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

FOR MORE INFORMATION ON YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE OR TO REPORT A VIOLATION OF THE ORDINANCE, CONTACT THE SUNSHINE ORDINANCE TASK FORCE AT 554-6075.

MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Down-town Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

MENTAL HEALTH BOARD
ATTACHMENT A
May 10, 2000

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed.

A. Approve Minutes of Prior Board Meeting

RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of April 12, 2000, be approved as submitted.

B. Approve Requested Leaves of Absence
Additional requests may be added at the Board meeting.

RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 10, 2000, to the following members: none.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

MENTAL HEALTH BOARD
ATTACHMENT B
May 10, 2000

PROPOSED RESOLUTION (MHB-00-xx)
COMPLETE AND ACCURATE DATA COLLECTION IN THE MENTAL HEALTH SYSTEM

WHEREAS, the Lesbian/Gay/Bi/Transgender Data Task Force sponsored by the Office of Cultural Competency and Consumer Relations of Community Mental Health Services has discovered a serious, significant, and unnecessary deficiency in data collection within the mental health system in San Francisco with regard to gender identity and sexual orientation, and

WHEREAS, a complete picture of who the mental health system is serving and what their needs are is crucial to providing appropriate care, and

WHEREAS, the number of lesbian, gay, bi, and transgender clients in the system as documented by the charts is significantly greater than the number of clients documented in the centralized data collection system, and

WHEREAS, the Task Force has identified key factors which are causing the incomplete collection of data, and

WHEREAS, the Task Force has prepared a detailed proposal for responding to this data collection challenge, and,

WHEREAS, the Task Force has also identified data collection deficiencies with regard to ethnicity, language, and heritage, now, therefore,

BE IT RESOLVED, that the Mental Health Board applauds and endorses the work of the Lesbian/Gay/Bi/Transgender Data Task Force, and recommends that Community Mental Health Services make every effort to carry out the provisions of the proposal and take whatever other steps need to be taken to correct the current data collection deficiency, and

BE FURTHER RESOLVED, that the Mental Health Board endorses the recommendation of the Task Force that every single area of data collection, especially including the areas of ethnicity, language, and heritage, be given the same attention and priority as is being recommended for the issues of gender identity and sexual orientation, so that Community Mental Health Services will have a complete and accurate data picture of the people they are serving.

MENTAL HEALTH BOARD OF SAN FRANCISCO

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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UNADOPTED MINUTES
Wednesday, May 10, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Jim Beauford, Ph.D. (Chair); Tim Agar; April Martin Chartrand; Renee Deger; Pat Harrison; Toye Moses, Ph.D.; Brian Peagler; Mickey Shipley; Chet Villalba; Barbara Williams.

BOARD MEMBERS ON LEAVE: Scott Ruble representing Supervisor Sue Bierman; Peggy Gilleran, J.D.; Lora Traveler.

BOARD MEMBERS ABSENT: none

PRESENTER: Deedee Jenson, California Institute for Mental Health

OTHERS PRESENT: Nancy Presson (CMHS); Marion Keller, L.C.S.W.; Emeric Kalman (Family Member); Bridgett Brown; Andrea Leung; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

I. CALL TO ORDER/INTRODUCTIONS
The meeting was called to order by Chet Villalba, Acting Chair, at 6:37 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-00-14): Be it resolved that the minutes of the Mental Health Board meeting of April 12, 2000, be approved as amended. (Passed)

The following paragraph was included in the Director's Report as a substitution for the paragraph in the unadopted minutes for April with regard to the State audit:

"Another finding required a more complete response. This finding related to answering the phone line in the evening. First of all we were asked to change the way we answer the phones. Instead of saying 'Access' we are now saying 'San Francisco Mental Health Access Line.' Second, there were difficulties with the AT&T Language Line's responsiveness to the calls that the State made to test the system. This is a Statewide problem that we will be trying to address with other counties. We will be working with our partner, Suicide Prevention, to meet the State requirements."

RESOLUTION (MHB-00-15): Be it resolved that the Mental Health Board grant leaves of absence for the May 10, 2000, meeting to: Scott Ruble representing Supervisor Sue Bierman; Peggy Gilleran, J.D.; Lora Traveler. (Passed)

III. PRESENTATION: THE ART OF ADVOCACY

Ms. Jenson: I worked with many of you at your Annual Retreat in December. I'm with the California Institute for Mental Health. My job this year is to work with 7 Mental Health Boards to help them become highly functioning Boards. Because your Reception is coming up and because it's a priority of your Board to be able to work with policy makers, we're going to focus tonight on advocacy. Your last Reception at City Hall was a success, and we're going to build on that success.

You have a fabulous mayor, Mayor Willie Brown. He can really work a room. He says that he learned how to do this from a book by Susan RoAne called *How to Work a Room*. One of the things you want to do when you go to your Reception is to be comfortable meeting people. There are two great fears in life—death and public speaking. RoAne says that working a room can be even a bigger fear.

Ms. Jenson then distributed the following handout:

> How to work a Room—Suggestions from Susan RoAne.
>
> Prepare a 7-10 second introduction like. "I'm Jane Doe, and I'm the director of the New Beginnings Birth Center. Our mission is to provide a healthy start to every mother and child."
>
> Use eye contact and a smile when introducing yourself.
>
> To enter a group of people already talking, stand in the periphery of the group, listen to the conversation, and nod appropriately in agreement when you can. Typically someone will welcome you and introduce him or herself. Once in a group, be sure to welcome others as they approach.
>
> Moving out of conversations is part of circulating. Limit your time in any one group or conversation to 8-10 minutes. To move on, just say, "Excuse me. It's been (lovely or interesting) talking to you or "It's been nice meeting you." Move to another part of the room to show you really did have someone to see or something to do.
>
> Conversations may begin with a comment on the facility, the food, the organization, the traffic, those attending or the purpose of the gathering. Avoid negative comments.
>
> Place your name tag on the right hand side.
>
> Have a strong handshake.
>
> Bring your sense of humor.

Ms. Jenson then asked Board members to break out into smaller groups to discuss priorities and strategies.

Group 1 Goals:
1. Cultivate new contacts among Supervisors and staff.
2. Maintain or increase mental health funding.

Group 2 Goals:
1. Talk with the Supervisors about embracing mental health priorities.
2. Network to find the staff who we can interact with specifically around mental health.
3. Want to find out from them how they would like us to inform them about our concerns and ideas as a Board. Phone call, card, through an aide, MHB "Snapshot."

Group 3 Goals:
1. Educate people in a diplomatic way about what we do.
2. Let people know about our current focus areas for the Board.
3. Come away with greater understanding of the Supervisor's interests.

Group 1 Strategies:
1. Board members engage Supervisors and staff in personal conversations.

Group 2 Strategies:
1. Connect with Supervisors and staff about issues which are of concern to them. Listen to their concerns and respond.
2. Listen to the Supervisors and staff and find the best way to relate or dialogue. Maybe budget issues would be a good place to start, or maybe it would be service issues.
3. Offer follow up, such as a phone call, coffee, or a lunch meeting.

Group 3 Strategies
1. Network in pairs.
2. Be prepared, so you can easily say what the MHB concerns and issues are.
3. Pick who you are going to focus on ahead of time.

Additional strategies:

We want to make sure we as Board members have done our homework, so we don't stumble.

Use the Annual Report to engage people in discussions about specific programs or issues.

If you see someone alone, connect with them and draw them in.

Key issues to focus on: funding, housing, homelessness, managed care.

Mr. Villalba: The theme of the Annual Report for this year is "Building on our Successes," which is a very positive message. The Report puts the needs of programs in this positive context.

IV. REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES

Ms. Presson: We got some good news last week about the budget. The Mayor's Office has accepted our request to add Medi-Cal revenue to the budget so we can hire 7 clinical positions. At the last MHB meeting I spoke about the hiring freeze and how difficult that's making it for us in our civil service programs. We are very committed to community treatment and keeping people out of hospitals. The City-operated programs are really the back bone of our outpatient services.

Last time, I said we hoped the freeze would be off by July, but that's not quite clear. We are down over 40 clinical positions across our system, so that's really hurting us. Our civil service programs have about 490 staff and we are down 60 positions and 40 of them are clinical.

We are also looking at one-time items in the budget, and are hoping to continue them. Last year, a talk line for parents was included in the budget at Supervisor Yee's request. It's getting up and going, and we'd like to see that annualized.

We're working closely with San Francisco General Hospital on how to implement the budget. We're working on how we can get people out of the hospital quicker. We have people in hospital beds who no longer need to be in the hospital, but no beds are open for them in the community. We have shortages across the system. We do not have enough state hospital beds. We don't have enough IMD beds or enough Board and Care beds for people with special medical conditions which require at least some nursing care. We need more supportive housing. Certainly the new ADU which opened last month is helping.

The OMI Clinic on Ocean Avenue near City College is undergoing renovation. It moved into a new site a year ago, and it's being relocated now for a few weeks. The physician's and urgent care will be located at Team II and the rest of the staff at the Thunderseed Socialization Program on Cesar Chavez Street. So this is clearly not the best situation. We're hoping it's very temporary and they will be able to move back into their building very soon.

Dr. Moses: What impact will that have on clients in terms of transportation? Ms. Presson: We have a car to transport people back and forth. Let me know if you hear anything in the community about how this is working. We're trying to be supportive of the clients and the staff, so they can have a building with good air quality.

Barbara Garcia has been working on integration of services in DPH. Right now she's looking at where different services have clients in common. Looking at possible ways our system could be more accommodating to people we serve. We're looking at ACCESS and the Bed Committee in Mental Health and TAP in Substance Abuse Services. We're looking at whether TAP and ACCESS can work more closely.

Dual diagnosis with substance abuse is something we've been looking at in many ways. There's a lot of interest in promoting the dual diagnosis policy signed by Substance Abuse Services and Community Mental Health Services. How this is actually going to work is something we need to work on, but there is an intention to have more collaboration between the two services.

Similarly, Barbara has arranged an interdepartmental effort to coordinate homeless services, and to tie that in with the Mayor's Office effort to do citywide coordination.

I have the draft of the SAMHSA grant for you to take and review. It will be on the agenda for the June MHB meeting. It's due to the State by June 30th, so there's time to study it and review it.

We were fortunate that Tina Yee and her office got another SAMHSA grant for outreach to the Filipino community. So we are moving one position off the basic SAMHSA grant. We'll be funding a Consumer Analyst for the Office of Consumer Relations to help do analyses of laws and cultural competency compliance by the programs, as well as looking at polcies that might be of interest for consumers to review.

Dr. Moses: I want to commend you for getting us the draft of the SAMHSA grant. In the past we've been bombarded with paper work on the day of the meeting. I'm glad to have a chance to review it.

I also would like to ask how the Mental Health Rehabilitation Facility is doing?

Ms. Presson: The MHRF is full. The statistics on discharging patients shows that the MHRF has been successful. I think it would be wonderful for you to hear from Mozettia Henley about how she sees things going. In the planning for the cuts of the SFGH beds, we have been working with the MHRF and Laguna Honda to see if there is some way to better meet the needs of the patients coming out of the hospital, especially responding to the clients who have medical problems as well as psychiatric problems. We're trying to figure out what our City's response is.

Dr. Moses: We used to have information and reports on Family Mosaic, so the fact that we're not hearing about them probably means things are going well there. Maybe you can update us sometime though and let us know what is going on there.

Mr. Agar: Do you have any insight into Barbara Garcia's initiative and Anne Kronnenberg's site visits around homelessness?

Ms. Presson: There are site visits all around. Barbara is committed to having an integrated approach to services for populations. And the homeless population crosses so many services.

Mr. Shipley: Barbara Garcia has been on the subcommittee of the DPH Strategic Planning Process, and that principle of integration has made it all the way up to the Steering Committee and the Steering Committee has adopted those principles themselves.

Mr. Villalba: Nancy, we find your reports wonderful and thorough and we really appreciate that very much.

At this point in the meeting Jim Beauford arrived and took over as Chair.
Dr. Beauford: I apologize to Board for being late. There was an emergency that came up with a client.

V. REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD

Ms. Brooke: I want to say a tremendous thank you to all the members of the Executive Committee for all the hard work on writing the Annual Report, which included weekend hours and late night hours. I'm really appreciative.

VI. COMMITTEE REPORTS

Executive Committee

Dr. Beauford: We spent most of the time going over the Annual Report. I want to give special thanks to Helynna and Rich for dedicated work on the initial drafts. And I especially want to thank Renee, Peggy, and Chet for all their work in writing the final version. There was a tremendous effort by a lot of people and I think it shows in the final report. I think it was a really great job. Ms. Deger: It was a good team approach.

Cultural Competency and Special Populations

Mr. Agar: The Committee again reviewed the resolution regarding the proposal by the Lesbian/Gay/Bi/Transgender Data Collection Task Force. This resolution was brought to March MHB meeting, and the Board sent it back to committee to do some broadening and make it more inclusive.

In bringing this back with only minor changes, the Committee wants to recommend that the Board endorse this proposal on its own merits and with minor changes that have been made. In working with the Cultural Competency and Special Populations Committee, it's a safe assumption that any group which brings their concerns or specialized needs to the Committee and asks us to be mindful of them and advocate for them would be given due attention. This group in particular brought a very specific request to us which we gave our attention and support to. We chose to go this route, the route of a resolution, in order for it to have full Board support. We'd move that the Board would pass this.

Dr. Beauford opened the floor to public comment. However, no member of the public chose to comment on the issue.

Ms. Williams: I spoke with Lora Traveler at the last meeting and tried to find out what her problems with the resolution were, and it was simply that she didn't feel that the original resolution was broad enough, and that it was focused on the lesbian, gay, bi, and transgender communities, and didn't take into account other minorities. It's the fact, that a lot of the information gathering is inadequate, so when it is time for funds to be allocated, people who are under counted are left out.

Mr. Agar: I think one thing this resolution does is it clearly states that our priority is to be specific in our data collection, so we can address the needs of communities not being adequately served.

RESOLUTION (MHB-00-16)
COMPLETE AND ACCURATE DATA COLLECTION IN THE MENTAL HEALTH SYSTEM

WHEREAS, the Lesbian/Gay/Bi/Transgender Data Task Force sponsored by the Office of Cultural Competency and Consumer Relations of Community Mental Health Services has discovered a serious, significant, and unnecessary deficiency in data collection within the mental health system in San Francisco with regard to gender identity and sexual orientation, and

WHEREAS, a complete picture of who the mental health system is serving and what their needs are is crucial to providing appropriate care, and

WHEREAS, the number of lesbian, gay, bi, and transgender clients in the system as documented by the charts is significantly greater than the number of clients documented in the centralized data collection system, and

WHEREAS, the Task Force has identified key factors which are causing the incomplete collection of data, and

WHEREAS, the Task Force has prepared a detailed proposal for responding to this data collection challenge, and,

WHEREAS, the Task Force has also identified data collection deficiencies with regard to ethnicity, language, and heritage, now, therefore,

BE IT RESOLVED, that the Mental Health Board applauds and endorses the work of the Lesbian/Gay/Bi/Transgender Data Task Force, and recommends that Community Mental Health Services make every effort to carry out the provisions of the proposal and take whatever other steps need to be taken to correct the current data collection deficiency, and

BE FURTHER RESOLVED, that the Mental Health Board endorses the recommendation of the Task Force that every single area of data collection, especially including the areas of ethnicity, language, and heritage, be given the same attention and priority as is being recommended for the issues of gender identity and sexual orientation, so that Community Mental Health Services will have a complete and accurate data picture of the people they are serving. (Passed.)

VI. PUBLIC COMMENT

Mr. Kalman: We had a big event on May 4th, the so-called Mayor's Committee 2000. To my knowledge there are about 74 members of this committee, and I want to ask the Mental Health Board if anyone represents the mental health system on this committee. This was an all day meeting, department heads and the Mayor, where they discussed policy and homelessness. We have about 4,000 official homeless people. At least half of them may have serious mental problems. I believe someone from mental health should be on this committee.

I also recommend that mental health be represented at the Board of Supervisors hearing on May 17th at the Finance Committee. This is a hearing about cutting the acute beds at San Francisco General.

Mr. Villalba: What is the relationship between inpatient psychiatry, and the decisions made by Community Mental Health Services? What is the role of the Mental Health Board members, other than as private citizens, in participating in discussions about closing inpatient beds?

Ms. Presson: We have a lot to do with inpatient services, because the San Francisco Mental Health Plan pays for those inpatient services. And although San Francisco General serves the greatest number of inpatients and most of the indigent, Medi-Cal patients have choice, and can go into other hospitals. Our office here authorizes payments for all Medi-Cal inpatient stays.

Secondly, we are the resource for people who are leaving the hospital who cannot simply go home. Many people who go through the hospital experience need ongoing care. There is a very close relationship between this office and the inpatient services. We have a great deal to say about what the capabilities of the system are, in terms of reducing hospitalizations and moving to community-based services.

Dr. Okin, if he were here would agree with that position. If we don't have the beds at SFGH, we will still pay for hospitalizations somewhere else. We want to be supportive of the efforts to move to community alternatives, but we want to make sure it's done in a planned way.

Ms. Keller: I would like to bring to the Board a study done by Protection and Advocacy entitled "Managing Mental Health Care: A Report on California's Medi-Cal Mental Health System 1997-1999." They bring up a lot of issues in this report, and I think it would be good for members of this Board to be familiar with this. They include the issues of re-hospitalization, and the comparative rates of involuntary hospitalization. San Francisco's rates are way above the state average.

Dr. Moses: I want to thank our staff for doing a wonderful job, especially our Executive Director who is just doing great. I want to thank Deedee, who is an excellent facilitator, for coming back and spending time with us. Mr. Agar: Deedee seems to be invested in us.

Ms. Harrison: I wanted to personally thank all of you for your support. The reason I missed the last meeting was that I was responding to four deaths. And my husband was in the hospital with heart failure and kidney failure.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:31 p.m.

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25/00

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

PUBLIC NOTICE

THE MENTAL HEALTH BOARD OF SAN FRANCISCO is holding a Reception for the members of the Board of Supervisors, their staff, members of the Mayor's staff, and the directors of ten selected programs in the mental health system, as well as the Guest of Honor, Sharon Johnson, Chief of Staff for State Senator John Burton.

The Reception will take place on Thursday, May 25, from 4-6 p.m. in the Mayor's Conference Room, which is Room 201 on the second Floor of City Hall at 1 Dr. Carlton B. Goodlett Place in San Francisco.

It is expected that a quorum of the members of the Mental Health Board will be present during the entire event. However, this is not a regularly scheduled meeting of the Board and no votes on any issue will be taken.

The Board will also be releasing its Annual Report on the Performance and Needs of San Francisco's Mental Health System. Anyone who wishes to obtain a copy of this report may contact the Mental Health Board office and a copy will be sent out immediately.

You can contact the office at:

Mental Health Board
1380 Howard Street, Suite 510
San Francisco, CA 94103
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MEETING OF THE FULL BOARD

Wednesday, June 14, 2000
1380 Howard, Room 537
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	5 minutes
II. CONSENT CALENDAR See Attachment A 1. Approval of May Minutes 2. Approval of Leaves of Absence for June	5 minutes
III. PRESENTATION: MENTAL HEALTH AND HOMELESSNESS Jennifer Friedenbach, Coalition on Homelessness, Project Coordinator of the substance Abuse Mental Health Work Group will present issues concerning mental ill persons who are homeless.	45 minutes
IV. REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES	30 minutes
V. REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD	5 minutes
VI. REPORT FROM MHB STATE LIAISON	5 minutes
VII. COMMITTEE REPORTS • Executive Committee, Chair's Report Request for approval of SAMSA grant • Additional Committee reports as needed	15 minutes
VIII. PUBLIC COMMENT PERIOD	10 minutes
IX. ADJOURNMENT	

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

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MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Down-town Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

MENTAL HEALTH BOARD
ATTACHMENT A
June 14, 2000

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed.

A. Approve Minutes of Prior Board Meeting

RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of May 10, 2000, be approved as submitted.

B. Approve Requested Leaves of Absence

Additional requests may be added at the Board meeting.

RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of June 14, 2000, to the following members: Barbara Williams.

MENTAL HEALTH BOARD
ATTACHMENT B
June 14, 2000

REVIEW OF THE SAMSHA GRANT

The Mental Health Board is required every year to review the renewal of the CMHS grant from the federal Substance Abuse and Mental Health Services Administration.

Nancy Presson will be able to answer specific questions about this grant at the Board meeting.

PROPOSED RESOLUTION

Be it resolved that the Mental Health Board send a letter to Nancy Presson, Acting Director, Community Mental Health Services, stating that the Board has reviewed the CMHS renewal proposal for the 2000-2001 block grant from the Sustance Abuse and Mental Health Services Administration, and that the Board gives its full approval and support to this grant.

DPH

MENTAL HEALTH BOARD OF SAN FRANCISCO

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UNADOPTED MINUTES
Wednesday, June 14, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Jim Beauford, Ph.D. (Chair); Tim Agar; Bridgett Brown; April Martin Chartrand; Renee Deger; Marushka France; Peggy Gilleran, J.D.; Andrea Leung; Toye Moses, Ph.D.; Mickey Shipley; Lora Traveler; Chet Villalba.

BOARD MEMBERS ON LEAVE: Scott Ruble representing Supervisor Sue Bierman; Pat Harrison; Barbara Williams.

BOARD MEMBERS ABSENT: Brian Peagler.

PRESENTER: Jennifer Friedenbach, Mental Health Substance Abuse Work group of the Coalition on Homelessness

OTHERS PRESENT: Nancy Presson (CMHS); Mike Wise; Emeric Kalman, Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

I. CALL TO ORDER/INTRODUCTIONS
The meeting was called to order by Jim Beauford, Chair, at 6:40 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-00-17): Be it resolved that the minutes of the Mental Health Board meeting of May 10, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-18): Be it resolved that the Mental Health Board grant leaves of absence for the June 14, 2000, meeting to: Scott Ruble representing Supervisor Sue Bierman, Pat Harrison, Barbara Williams. (Passed)

Mr. Beauford: Pat Harrison's husband, David "Scooter" Morris, passed away last week. The Board sent flowers to Pat. Lora, Helynna, and Rich went to the memorial at Glide Methodist Church to represent the Board.

We're moving agenda items around to accommodate different people's schedules. We'll start with the grant proposal to the federal Substance Abuse Mental Health Services Administration (SAMSHA).

Ms. Presson: This is our annual submission to the State for SAMHSA grant. I want to introduce Dr. Steve Seidman, Director of the ACCESS unit. He is the point person for SAMHSA, which makes sense because many of his staff are in the SAMHSA grant.

We have an interesting problem with SAMHSA. They never increase the dollar amount, and yet we have to pay people more. So we have to add in General Fund dollars.

The grant includes clerks, social workers, and crisis social workers in ACCESS. It also includes money for mental health education. Tina Yee was able to get a special grant to cover the Filipino health educator, so that position is no longer included in the SAMHSA grant.

We've included a position for Tina's office for consumer support. We have not be able to hire for that position because of the hiring freeze. We've moved it into the grant because that will make it easier to fill the position.

There is also a portion of this grant earmarked for seriously emotionally disturbed children and youth. The grant helps fund some of the staff at the Family Mosaic Project and also funds some of the early intervention activities for very young children, primarily in child care centers.

Mr. Villalba: I'm interested in the whole question of the Consumer Family Council. Is that developed yet? Ms. Presson: Tina is working on that. Mr. Villalba: Will it be for children or adults? Ms. Presson: Adults. Mr. Villalba: That's good because that's a gap in the system.

Dr. Beauford: Is parity going to affect your program? And how will that affect your inflow? Will there be more crisis cases and acute cases? Will you be able to address those people with the same budget? Dr. Seidman: Some people will be able to get services they weren't able to get before from their insurers, so we're not anticipating a great influx.

Mr. Villalba: SAMHSA is both mental health and substance abuse. Does this grant cover dual diagnosis? Ms. Presson: That would be lovely, but this is only the mental health piece.

RESOLUTION (MHB-00-19)
Be it resolved that the Mental Health Board send a letter to Nancy Presson, Acting Director, Community Mental Health Services, stating that the Board has reviewed the CMHS renewal proposal for the 2000-2001 block grant from the Substance Abuse and Mental Health Services Administration for a total of $1,267,103, and that the Board gives its full approval and support to this grant. (Passed)

Dr. Beauford: I'd like to introduce Bridgett Brown who was just appointed yesterday by Supervisor Leslie Katz to a Consumer Seat. She works at the Independent Living Resource Center, and brings a real understanding of the disabled community to her position.

I'd also like to introduce Marushka France who was appointed three weeks ago by Supervisor Mabel Teng to a Family Member Seat.

III. PRESENTATION: Mental Health and Homelessness

Jennifer Friedenbach: I want to talk a little about the Coalition on Homelessness (COH) and how it works, so you'll have context of where I'm coming from. Then I'll talk about the Substance Abuse Mental Health Work Group of the Coalition. Mickey Shipley and Mike Wise are members of the Work Group. Then I wanted to let you know about our agenda, and a lot of it matches what you've been working on.

COH has been around 12 years, and is an organization made up primarily of homeless people and formerly homeless people. We work to organize homeless people so they can have a strong voice in creating solutions to homelessness and poverty so we can develop permanent exits from homelessness. We don't provide direct services, but advocacy. We don't provide soup in soup kitchens, but work so people won't be waiting in line at soup kitchen.

Our constituency is homeless people, so that means our organizational methodology is somewhat different from the traditional community organizing methodology.

One of our projects focuses on women of color who have been homeless. We focus on issues mothers have with homelessness and child protective services, including the racist things behind CPS. We work to keep families together. We deal with welfare rights issues and criminal justice issues.

Another project focuses on homeless Latinos in the Mission District.

Our civil rights project works to protect the human and civil rights of homeless people out on the streets. We try to get the police to stop arresting people for being homeless, and we work to stop the criminalization of homeless people. But we are losing that battle; the situation has worsened over the past four years.

People know us by the *Street Sheet*, our monthly newspaper. There are 36,000 copies distributed by homeless people each month, and they get to keep the dollar they get for each paper. We've been able to create a lot of change through the *Street Sheet* alone.

We talk with 700 homeless people each week, asking them what they want us to be working on and sharing with them what we're doing. This helps hold us accountable. Our agenda comes from what homeless people tell us they want us to work on.

Locked Out: The Voices of Homeless People with Mental Illness is a survey around mental health issues. We talked with homeless people who have mental health issues and asked them what kind of changes they'd like to see in the mental health system. That information formed the basis for our agenda at the Substance Abuse Mental Health Work Group. We talked to 282 adults, both men and women, in lots of different locations. We collected really valuable information.

Of those surveyed, 92% wanted treatment and said if programs met their needs, they'd enter treatment. City Hall says that homeless people are refusing treatment and don't want it. We found out that people want treatment and know exactly what kind of treatment they want.

One-third of people who tried to get treatment, didn't get it. Fifty percent of people CMHS approves never show up for treatment. We got 30% in our survey, but that's still significant. Almost all of the trouble was around ACCESS to the program. It was too complicated. Mental health issues prevented people from navigating what they experience as a very complicated treatment system. A lot of folks kept trying to get treatment again and again; a lot had tried within the last couple months before the survey. A lot of people who managed to get treatment only got it for a short time. Twenty-five percent of folks who got treatment got it for only less than a month.

The other huge piece, and something for the MHB to take seriously from our perspective, was that more than 50% had negative experiences in terms of treatment. The most common reasons were that it was too cumbersome a process to ACCESS services and it took too long. People told us things like, "I was trying to get back on medications and it took too long and I ended up back in prison. "

This is a really huge step to take, to call out for help, and people probably are in a crisis when they are calling out for help. When they get a run-around it creates more drama and crisis in their lives.

People talked about being denied meds or treatment, bad experiences with staff, and being kicked out of treatment.

Of the people who had a positive experience, the most common reasons were they like the talk therapy, they found a safe and comfortable environment, and the staff were empathetic and able to deal with medication.

The staff were crucial. They either made the experience or blew the experience.

When people were asked about the ideal program, their responses centered around the kind of staff they wanted: dedicated, friendly, supportive, calm, serious, non-judgmental, and with good time management skills.

Second biggest set of responses were that they wanted treatment on demand, so when they reach out for it they get it. They wanted programs that included work and recreational activities so they could get back involved in the community and have a more fulfilling life. They wanted integrated services and peer support.

People knew what services they wanted. It's no big surprise, that the number one thing they wanted was housing. People saw housing as integral to their mental health. Housing, one-on-one counseling, and medication—those were the top three in that order. They also wanted job training, nutrition counseling, SSI advocacy, and 24 hour services.

Mr. Villalba: How do you evaluate when somebody says I want a therapist who has all the good things we expect a therapist to have. How do you evaluate the therapist based on these comments? How does the system evaluate therapists based on a study like this? Ms. Friedenbach: We take people at their word, and these were comments we heard over and over again. It was a common theme.

One of the ways to build up the accountability is to have an independent grievance procedure. There needs to be an advocate for the client, so people can call the advocate when they have issues. There needs to be centralized information that can be acted on. This is one piece of accountability. If the same issue comes up over and over or one staff is generating lots of complaints then action can be taken.

Mr. Agar: Jenny, it's good to have you here. When you rolled this report out, it was April 1999. What impact has this had in the last year?

Ms. Friedenbach: The document has been really well read by policy makers in different departments. It influenced the single standard of care funding that the Mayor's Office approved last year. The shelter system is looking at it closely as well. We're losing so much ground in terms of the budget this year, that it's hard to know what the effect is beyond raising awareness.

Ms. France: I was reading a study recently that said if a person wishes to receive treatment, if they just get 1 or 2 sessions they do worse than if they didn't get any treatment at all. Were you able to see any correlation between positive answers and length of treatment. Ms. Friedenbach: We did ask that, but haven't correlated it.

Ms. Friedenbach: One reason the survey worked is that it was peer-based. Everyone who did the interviews was homeless or had mental health issues or both. We did a Freedom of Information Act request of CMHS, and wrote up a summary of what we found. These are things the COH loves to do; we do them all the time. We got back a lot of information in a binder that was very well organized.

In terms of the impact of the budget cuts, there is $4.7 million in cuts. Of that $1.1 million is cut from outpatient treatment. There are 54 positions frozen. The cumulative effect of all this has been really devastating to folks. There is a loss of outpatient treatment for 330 people. And that is really shocking in light of the fact that the Director of Public Health was arguing for moving people from the hospital to community based services. And it turns out the cuts to the community based services are far deeper than the cuts to the hospital. At the hospital, 65% of the costs are reimbursable, so the City is saving only 35% of the costs. Cantonese and Spanish speakers are especially impacted.

Of the frozen positions, 71% are clinical positions, and 20 positions are for people who can provide treatment in languages other than English. There are 10 full-time positions for children's services being cut. A position at the OMI Family Clinic serving 200 African American children is being cut.

Most clinics are closed to new clients. ACCESS can't refer people there. Many of the larger clinics are not taking new people. People have to wait weeks and weeks for an appointment. People are ending up in the hospital. People are ending up being incarcerated who don't need to be incarcerated.

There is a 10-15% diminished capacity of clinics. Some of the clinics are really hit hard.

At COH we're always aggressive of course, but also very positive thinkers. Because of the mental health system being decimated for so many years, we need to focus on a strategy of building up the capacity of the system.

We're asking for 2.7 million in additional funding. In the Mayor's budget we got absolutely nothing. We're disappointed because the Mayor has been somewhat decent about mental health issues and talks a lot about it.

The Coalition is requesting $700,000 more for residential care. We need to build up capacity. If we can do a ball park, we can do residential care. We need programs for dual disorders. We need to have it be that people can stay in residential care as long as they need.

We're requesting $50,000 more for Patients Rights Advocacy Services. PRAS needs an additional advocate to deal with ACCESS issues.

We're requesting $261,913 for Medi-Cal and SSI advocacy. We need an advocate for SSI for all mental health clinics. Most of the clients should be on SSI. The City is losing a lot of money because of this. We want to see 150 people under this new funding. Ninety people getting on benefits would give the City $1.3 million back for an investment of $250,000.

We're requesting $200,000 for job training.

We're requesting $304,512 for 10 new peer counseling positions.

We're requesting $900,000 for 24 hour services capacity. We want some place people can go when they're in crisis. The Police Department reports that the majority of their calls have been in the off hours and there is no place to take people apart from PES. We're proposing that DPH put a work group together to design this. We want a physical location, a place for people to go.

Mr. Villalba: I haven't heard that there was a waiting list and that new patients couldn't get into clinics. How long has that been happening?

Ms. Presson: The effect of the freezing of the positions has been devastating to us and it's gotten progressively worse, because as staff leave we can't replace them. And spring has been devastating. Interns cannot take new cases after a certain time in the spring. In the area of children's services, teachers seem to start to worry about kids at this time of year. That and other reasons mean we get an increase of referrals.

Mr. Villalba: From the Board point of view, it is not acceptable to have people waiting. I think this is an absolute priority. I think that this is unconscionable. I can't stay on this Board if we don't take this as a top priority. I really think it's awful.

Ms. Traveler: I want to applaud Chet, and say thanks to Jenny Friedenbach for bringing this information to us. Millions of dollars are spent for other things in this city and it sends me up the wall to turn people with mental illness away from treatment.

Dr. Beauford: I agree with you, Chet. We need to get the information out. We do have connections and know people and I think we need to follow up on all the networking we've been doing. Individual board members all have Supervisors we can send a letter to.

Mr. Villalba: I thought we were very successful when we scheduled appointments to meet with the Supervisors personally. If we can't see people who want treatment, then the system is not functional. We need to let the Supervisors know that as a Board we have a major, major concern.

Ms. Gilleran: The most consistent message from the Board of Supervisors through our appointments with them is that they wanted us to isolate for them, in a clear statement, a single thing we want.

Mr. Agar: Would it be reasonable for us to get data on the last 6 months of which clinics are closed to new clients, or the past 5 months?

Ms. Deger: Can we get an idea over the last 15 months, what clinics have been closed for how long and how many people have been turned away?

Ms. Presson: We do get a report that has admissions per clinic. I'll follow up on this for you.

Mr. Villalba: I understand the cycle, but this is probably more true in California than other places. This state is so dependent on trainees, and there is nothing wrong with training. But to have a staffing pattern that is so dependent on interns in training is not appropriate. It's very hard being an intern. But most systems use interns as staff members. And I think we need to be aware of that, and not acquiesce and say that's wonderful. It isn't wonderful.

Ms. Presson: California is so low on per capita mental health funding. At one point it was 49th in collecting Medi-Cal for mental health services. So we have a long way to go.

Mr. Wise: I was one of the people who worked on the COH survey. What kept coming back, was that we need outreach. Not another position in an office somewhere. People got lost in their appointments, and got lost in the whole machinery. We need people to go out to the shelters and out to the streets and make contact.

Ms. Friedenbach: People weren't specifically asking for outreach workers, but were saying that they were having trouble with ACCESS. That's why we are requesting extra staff at PRAS. We've had a long standing position on supporting more outreach workers, but until there is more capacity in the system it doesn't help to have more outreach. The outreach workers out there already are connecting and can't get their clients into treatment.

4. REPORT OF THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES

Ms. Presson: One of the reasons I work in San Francisco is because of the work of all the advocates. Most counties don't have the kind of advocacy we've heard about tonight.

The parity bill is of great interest to us. We've been approached by a couple large insurers, and we want to be extremely helpful in HMOs meeting their obligations for mental health coverage. There's a concern on our part because we've been dealing with under-insured people. We want to make sure parity works. It may result in more calls for crisis services from us. We do think HMOs will be taking better care of their enrollees.

Our Medical Director Peter Forster has resigned. He's one of the most energetic people I know. We've been so fortunate to have him here over the past three years. He's going into the world of dot-coms. We are going to be seeking a new Medical Director. Mitch Katz has promised me that that position would not stay frozen.

There is a concern on the part of family members about accessing assistance when they are in need. There are a number of CMHS administrators who respond to these requests and some family members get help. But access is not easy. There is no ombudsman to help. I talked with Tina Yee this morning. Her office is very anxious to work on this issue. We want to talk with the MHB about how to make our system much more accessible to family members.

Ms. Deger: As President of the San Francisco Chapter of the National Alliance for the Mentally Ill, I want us to be involved. People can't even get simple questions answered by ACCESS.

Ms. Presson: Some of the concern is coming from what we've heard from NAMI members. I'm not sure what we'll do, but I do know that what we're doing now is not working.

Ms. Deger: I have job descriptions from two other counties in the state who have family member liaison people on staff. I'll send those to you.

Mr. Villalba: I think it's good that you're studying this. In children's services there's a Family Involvement Team. I know there's the business of confidentiality and rights. However other counties deal with it somewhat differently, and there is much better accessibility to families. Families may need services in addition to an ombudsman. We have prototypes for children and families. But for some reason my sense in San Francisco is that accessibility for families is rare. And there's something in the attitude that blames parents. The way we don't involve families in San Francisco should be reviewed.

Ms. Presson: I wanted to report that the Westside adolescent day treatment program and school is closed for the summer due to staffing and funding issues. The leadership at Westside felt they did not have sufficient staff for summer school There is contention around this decision. We have asked Westside to let us know in writing what their intentions are. There will be a hearing at the Finance Committee of the Board of Supervisors on this program on July 19th. They had 11 adolescents there, and we are low in day treatment slots, so this is a problem for us.

Dr. Moses: I hope your department can really, really advocate for continuation of this service. For Westside to stop that program, why? Do you have another program for those children? Ms. Presson: The staff here and at the School District have worked out other treatment placements for each of those children.

Ms. Deger: Next month I think the Board needs to get a very erly start on the budget for fiscal year 01/02.

5. REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD

Ms. Brooke: I'd like to introduce Andrea Leung, a new member of the Mental Health Board, who was appointed by Supervisor Leno to a Public Interest Seat. We hope she will help us to get much more in touch with the Asian community.

We still have one open seat on the Board, a Consumer Seat. Applications have gone to the Rules Committee of the Board of Supervisors. The money for the Police Crisis Intervention Project has been rolled over to the next fiscal year. We will be continuing to develop the curriculum.

We have been getting an amazing response to the Annual Report. I want to acknowledge Renee, Peggy, and Chet for all their hard work, and especially Renee for staying till 12:30 at night a couple times working on the Report.

7. COMMITTEE REPORTS

Executive Committee

Mr. Beauford: I want to thank all the MHB members for participating in our Reception. I want to announce two appointments. Tim Agar has been appointed Chair of the Cultural Competency and Special Populations Committee. Mickey Shipley has been appointed as our State Liaison. Mickey has provided us with a wealth of information. This appointment is long overdue. Thanks, Mickey, for all the work you've been doing.

> RESOLUTION (MHB-00-20)
> **Be it resolved that the Mental Health Board cancels its regularly scheduled meeting for August 9, 2000. (Passed)**

Path Grant

Ms. Presson: This is the state allocation to CMHS for services for the homeless mentally ill. With that money, we support the MOST Team at the South of Market Clinic, Swords to Plowshares for homeless vets outreach, and a small grant to Episcopal Sanctuary to increase their outreach.

> RESOLUTION (MHB-00-21)
> **Be it resolved that the Mental Health Board send a letter to Nancy Presson, Acting Director, Community Mental Health Services, stating that the Board has reviewed the CMHS renewal proposal for the 2000-2001 grant from Projects for Assistance in Transition from Homelessness for a total of $116,336, and that the Board gives its full approval and support to this grant. (Passed)**

Dr. Moses: I'm waiting to hear about acupuncture. We've been talking about this for the past three years, so please don't forget to support this in the budget.

6. REPORT FROM THE MHB STATE LIAISON

Mr. Shipley reported on a recent meeting of statewide associations of mental health organizations and provided handouts to distribute to the Board. He then commented as follows: The State is on the verge of losing its waiver from the federal Health Care Financing Administration (HCFA). Four counties are being investigated for mismanagement of the funds, and for HCFA that's enough. The California Association of Local Mental Health Boards and Commissions (CALMHB/C) is going to have a regional training on July 29th from 10-3 in San Mateo on HCFA. People from HCFA are going to be there along with staff from Protection and Advocacy. I was told, it's very important to try to get all our board members there. It's a matter of life and death for the state and the counties with regard to mental health funding.

Dr. Moses: I wanted to take this opportunity to thank the staff for doing an excellent job. And to thank Nancy for her work; it's just incredible.

In response to a question by Ms. Deger, Ms. Presson replied: There's been a mental health forum meeting on an ongoing basis. It's a small group of about 15 people focused on adult services, who are figuring out what do we mean by a system of care and how do we reduce hospitalization. I co-chair it with Steve Fields, and I think Mitch Katz and Barbara Garcia are really committed to this process. I think there is funding available for systems of care that can describe themselves. We have a lot of deficits in our system. If we want to be competitive, we have to be able to describe what we are wanting to do as a system. The children's system has about a ten year head start on this over the adult system.

We need to figure out what we're doing in San Francisco in comparison with the state template. There's a concept at the state level of a recovery emphasis. The next step for us is where does the recovery model of mental health fit in, and how does San Francisco respond to a state template that we are being asked to address. Other counties have developed recovery task forces. We need to develop a dialogue so we can be as articulate about adult services are as we are about children's services.

VI. PUBLIC COMMENT

Mr. Kalman: I would like the Board to invite the Continuum of Care representatives to make a presentation. There was an editorial in Sunday's Chronicle about the neglect of mental illness. What I see in the editorial is devastating. Helen Thomson's bill is being held up by John Burton's $87,000 study of involuntary treatment programs. We can say good-bye to all this work on this bill. It's tragic that Burton is stopping this. Someone should contact Senator Burton's office.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:49 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE FULL BOARD

Wednesday, July 12, 2000
1380 Howard, Room 537
6:30 p.m.

AGENDA:

1. **CALL TO ORDER, INTRODUCTIONS** 5 minutes

2. **CONSENT CALENDAR** See Attachment A 5 minutes
   a. PROPOSED ACTION: The Board approves June minutes
   b. PROPOSED ACTION: The Board approves leaves of absence for July

3. **PRESENTATION: Status of Mental Health Services in Schools** 45 minutes
Panel presentation about the status of mental health services in the school system. The panel members are: Sally Chou, Assistant School Superintendent, Albert Eng, CMHS, and German Walteros, Instituto Familiar de La Raza.

4. **REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES** 30 minutes

5. **REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD** 5 minutes

6. **REPORT FROM MHB STATE LIAISON** 5 minutes

7. **COMMITTEE REPORTS** 15 minutes
- Executive Committee, Chair's Report
    1. PROPOSED ACTION: The board approves an ad in the Street Sheet thanking the Coalition on Homelessness for its work on the mental health budget (Attachment B)
    2. PROPOSED ACTION: The board approves presentation of a Lifetime Achievement Award to Supervisor Sue Bierman. (Attachment C)
- Additional Committee reports as needed

8. **PUBLIC COMMENT PERIOD** 10 minutes

9. **ADJOURNMENT**

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health

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(Chapter 67 of the San Francisco Administrative Code)

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1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Down-town Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

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SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

MENTAL HEALTH BOARD
ATTACHMENT A
July 12, 2000

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed.

A. Approve Minutes of Prior Board Meeting

RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of June 14, 2000, be approved as submitted.

B. Approve Requested Leaves of Absence

Additional requests may be added at the Board meeting.

RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 12, 2000, to the following members: Tim Agar, Barbara Williams.

MENTAL HEALTH BOARD
ATTACHMENT B
July 12, 2000

RESOLUTION TO THANK THE COALITION ON HOMELESSNESS

For years the Coalition has been engaged in vigorous, unflagging advocacy for increased funding for mental health services, and has made a crucial difference in this year's budget victory.

PROPOSED RESOLUTION: Be it resolved that the Mental Health Board place the following ad in the Street Sheet in appreciation of the work of the Coalition on Homelessness:

The Mental Health Board
says Thank You
to the Coalition on Homelessness!

We so much appreciate your dedicated advocacy for mental health services for homeless and other underserved people. This year's budget is a victory, especially for the Single Standard of Care. Thank you for the key difference you made!

MENTAL HEALTH BOARD
ATTACHMENT C
July 12, 2000

RESOLUTION ON A LIFETIME ACHIEVEMENT AWARD FOR SUE BIERMAN

Sue Bierman has been a champion for mental health services during all her years on the Board of Supervisors. Both last year and this year, during the budget negotiations she has made funding for mental health, particularly the Single Standard of Care, her top priority. This is a remarkable commitment, and her advocacy has made all the difference..

PROPOSED RESOLUTION: Be it resolved that the Mental Health Board present its first ever Lifetime Achievement Award to Supervisor Sue Bierman for her years of championing mental health services in San Francisco, to read as follows:

The Mental Health Board of San Francisco
presents its very first

Lifetime Achievement Award

to

Supervisor Sue Bierman

For making mental health services your top priority in budget negotiations,
and for your unfailing commitment to serving the people of San Francisco,
especially those most in need.
We are so proud to have you on our Board,
and are so thankful for our partnership with you.
We will keep you in our hearts always.

Jim Beauford, Ph.D.
Chair, Mental Health Board
July 12, 2000

DPH

MENTAL HEALTH BOARD OF SAN FRANCISCO

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UNADOPTED MINUTES

Wednesday, July 12, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Jim Beauford, Ph.D. (Chair); Bridgett Brown; April Martin Chartrand; Renee Deger; Marushka France; Andrea Leung, L.C.S.W., A.C.S.W.; Toye Moses, Ph.D.; Brian Peagler; Mickey Shipley; Lora Traveler; Chet Villalba.

BOARD MEMBERS ON LEAVE: Tim Agar; Scott Ruble representing Supervisor Sue Bierman; Peggy Gilleran, J.D.; Pat Harrison; Barbara Williams.

BOARD MEMBERS ABSENT: none

PRESENTERS:
Sally Chou, Associate School Superintendent, Student Support Services, San Francisco Unified School District
Albert Eng, Assistant Director for Outpatient Services, Children, Youth, and Family Section of Community Mental Health Services
German Walteros, Early Intervention Coordinator, Instituto Familiar de La Raza

OTHERS PRESENT: Linda Wang (CMHS); Albert Eng (CMHS); Kevin McGirr (CMHS); Mike Wise (San Francisco Network of Mental Health Clients); Connie Colvin (Sonoma County Network of Mental Health Clients); Elsie R. Cohen; Emeric Kalman (Family Member), Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Jim Beauford, Chair, at 6:40 p.m.

2. CONSENT CALENDAR

RESOLUTION (MHB-00-22): Be it resolved that the minutes of the Mental Health Board meeting of June 14, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-23): Be it resolved that the Mental Health Board grant leaves of absence for the July 12, 2000, meeting to: Tim Agar, Scott Ruble representing Supervisor Sue Bierman, Peggy Gilleran, Barbara Williams. (Passed)

3. PRESENTATION: Status of Mental Health Services in Schools

Mr. Eng: What I plan to do is give an overview of the range and types of services CMHS provides in the schools. I have a handout for you entitled, "CMHS Services in San Francisco Unified School District Sites and Child Development Centers." This is still in development.

CMHS has been involved at school sites for over 20 years. One of the longest standing programs is the Galileo Adolescent Program (GAP) at Galileo High School. It's staffed by clinicians from the Chinatown/Northbeach Mental Health Center. Over 20 years ago the staff there took it upon themselves to be involved in the community and have been at Galileo ever since. They provide drop in services and consultation to teachers. Sally Chou was formerly at that site and she can tell us more about it. CMHS is very proud of this program.

We provide AB 3632 Services. These services are our SED mental health partnerships. SED stands for seriously emotionally disturbed. These services are also know by the number of the legislative chapter, Chapter 26.5, which calls for services to be provided, if parents desire to have them, for students free of cost, if the students are eligible.

The Children, Youth, and Family Section of CMHS does a lot of coordinating of services with Special Education at the School District, and now recently we are working more with general education students than we have in the past.

I'd like to go over the titles of the columns on the handout to give you an idea of the range of services we provide. The first column is General Consultation. This involves working with the School District as a whole. It includes consultation to and participation in interagency case planning and case review initiatives.

The second column is Emotionally Disturbed/Mental Health Special Day Class Partnerships. About 7 years ago CMHS started drastically cutting inpatient services by providing more services to help children stay out of the hospital. This money which was formerly spent on inpatient services was reinvested in programs in the community. We.are now providing these services to 47 classrooms in 30 schools.

We pay providers to work 12 hours a week in each of these classrooms, and the size of the class is usually 8-12 students. Most of these services are provided by contract, although some are provided by our Civil Service programs. We are able to bill for some of these services and help offset the cost. The very existence of these programs is due mainly to Sai-Ling Chan-Sew who conceived of the programs and arranged for the funding.

About 4 years ago we started getting funding from the state called Early Prevention, Screening, Diagnostic, and Treatment (EPSDT) funding, and this has allowed us to expand our services.

The next column is Childcare Mental Health Consultations. Two years ago, Sai-Ling Chan-Sew, in concert with the Department of Children, Youth and Their Families and Supervisor Mabel Teng, pulled together consultations in 17 School District child care centers, plus others in the community. There are mental health clinicians placed at these sites a few hours a week, and they work with the staff on how to help children who are having a hard time adjusting. They also do early intervention.

The next column is Special Consultation to SFUSD. This involves clinics providing mental health consultations to nearby schools.

The next column is Integrated Primary Care/Mental Health Collaboratives. These programs were set up under Proposition J funding. They involve pairings between Department of Public Health primary health clinics and mental health clinics to set up satellite clinics for youth. Also in this category is the Balboa Teen Clinic, which is a primary integrated healthcare clinic at Balboa High School, including a mental health component.

The next column is the Safe Schools Healthy Students Initiative. Trish Bascom from the School District is here and can talk more about that. They're planning to work in 7 high schools and 10 elementary schools, and set up wellness clinics there. CMHS would be one of many players in each of these clinics.

The final column is the Primary Intervention Program (PIP). Since 1986, PIP has been at 3-5 sites each year, usually K-2nd grade. It works with kids who are on the quiet side, who don't act out and might otherwise be missed, CMHS provides consultation to the paraprofessionals who are doing nondirective play with these children.

Altogether we are providing services to 60 schools.

Ms. Chou: I want to first introduce Trish Bascom, the Supervisor for School Health Programs Department. School Health is no longer what it was years ago. Trish has been writing a lot of grants. She's brought in millions of dollars for our programs.

Howard Blonsky is a social worker in the Special Education Department. He works with middle and high schools in training and the delivery of student assistance programs. We provide a special assessment process before referring students anywhere.

What I'm going to talk about is more on the preventive side. I came up here from southern California to become principal at the Galileo Academy. The first thing I was introduced to was the Galileo Adolescent Program (GAP), where referrals can be made to the program immediately. There is ready accessibility every day.

I'm the Associate School Superintendent for Student Support Services. I'm responsible for all the programs under support, including bi-lingual, gifted and talented, special education, and high school and middle school athletics programs. The perspective we take is to support the whole child.

After Proposition 13, lots of school programs got cut. These were considered superficial services. We lost librarians, counselors, nurses, psychologists, so we have had to make up for the loss in other ways.

Right now there are about 750 students for every school counselor, so the counselors can't do mental health counseling. They do student programs and scheduling.

We have a Crisis Response Team which Trish handles. For example, a teacher died at a prom. We kept that from the kids that night. But then we brought in counselors on the following Monday morning.

In all of our middle schools we have nurses. Through grants, Trish was able to provide this. In the middle schools we're looking at at-risk behaviors and trying to catch students before things get worse.

In elementary schools we have special liaisons who work with parents.

We use a Student Success Team approach for elementary schools. If a student is having trouble the teacher can make a referral to the program.

We often make referrals to outside agencies, because we don't have a lot of services in the District itself. We have become very aware of community programs, like German's. When I was at Galileo, we connected with lots of organizations. The principals become very familiar with these services and make referrals.

We have Peer Resource Programs, focusing on the young people solving issues themselves, solving them before they become big problems.

This year I happened to be very involved with Sai-Ling and DOCYF to get money out of Proposition J to fund wellness centers. After lots of negotiations we are now implementing a center at Galileo.

There are also other programs like Healthy Start, and many of you are aware of the Beacon Centers. We also get funding from the Probation Department and work closely with them.

Mr. Walteros: I'm the Early Intervention Coordinator at Instituto Familiar de la Raza, which is a community-based agency primarily in the Mission. In the last ten years, though, we've expanded to serve other groups. We've worked closely with CMHS, since Sai-Ling came on board. She's been an unconditional supporter of these kinds of early intervention services.

We go out and provide services to child care centers. We work with 1 School District children's center, 5 Headstarts, 2 nonprofit centers, and 25 family day care providers—who are historically a neglected part of the child care field.

I want to give you a handout which is based on a concept from the World Health Organization. It's a reversed pyramid. Traditionally in the United States over 80% of mental health money goes to treatment. WHO says it shouldn't be over 5 percent. The rest should go into prevention and early intervention. We need to begin to promote well being. That's where the focus should be, in promoting mental health and promoting cultural activities. There's only one thing you can build on top of success and that's success. There's only one thing you can build on top of failure, and that's failure.

At Instituto, our School Based Mental Health Model is as follows:

PROMOTING WELL-BEING
Promotion of protective factors
About 35%

PREVENTION
Eliminating/reducing conditions that create risk factors
35%

EARLY INTERVENTION
Direct intervention to reduce/eliminate risk factors
25%

TREATMENT
Outpatient and other higher level treatment
2-5% of children and their families

The mental health practitioner needs to go into the classroom and work with the teachers. Traditionally, the focus is on the children who are having problems. The practitioner takes them out, provides treatment, and then puts them back in the classroom. The new strategy is to focus on the classroom, create optimal environments, and reduce the risk factors. If we attend to the individual problems, but don't look at the classroom, there won't ever be enough of us to respond to the demand.

The mental health community and the community that educates children, need to be focusing on prevention. This is the model we're implementing. This is turning the world upside down.

Dr. Moses: First I want to commend all three of you for the services you are providing for our children, especially with limited resources.

In Bayview Hunters Point, we have a lot of schools, and I don't see them well represented on the handout from CMHS. Does that mean they are not getting services?

Mr. Eng: Within the school district, there have been 20 years of busing students out of Bay View Hunters Point into other parts of the city. Our first mandate is to serve special education students, and those classrooms are throughout the city. They are called special day classes. The kids come from Bayview Hunters Point and throughout the city to these classes.

Dr. Moses: I would think for the sake of convenience, it would be good to have sites located in Bay View Hunters Point. And I would like to ask how many CBO's from the African American community are represented among the providers.

Ms. Chou: In response to your first question, we don't have that many classes in Bayview Hunters Point. We've had a court order for desegregation so lots of kids have been moved out to other schools. The two high schools in BVHP are both alternative high schools where kids have to apply to get in. However, the services follow the kids wherever they go.

With the consent decree coming to an end, more and more students are going back to school in their neighborhoods.

Although CBO's are run by African American organizations, they have staff from a range of ethnicities. Even with the Chinatown program running the GAP, the program serves everybody who's at Galileo, which is a diverse group of students. There's a big chunk of Chinatown kids who go to Mission High School, and a big chunk of kids from Mission come to Galileo. African Americans make up 17% of the population at Galileo and students from the Mission District make up 17%, and there are many kids from the Tenderloin. As site administrators, we have to look at the kids in the school and get the services that match the kids. We're seeing the ethnicities of the schools changing now with the consent decree being taken out.

Mr. Eng: One of the agencies that provides the most services to the schools is the Bay View Hunters Point Foundation. They provide services at Hoover Middle School and Giannini Middle School. Two of their three staff are African American. The Children, Youth, and Family Section of CMHS is committed to providing services at every single SED Special Day Class in the city, regardless of geographical location.

Mr. Shipley: You said that in the middle schools the nurses do assessments. How much training do those nurses get on the emotional needs of those children? A lot of the young children come from very different situations, different economic, family, social backgrounds. So they're dealing with different problems. Nurses are medically trained, so how can they deal with these other issues?

Ms. Bascom: Most medical people are trained in the medical model. But what we've done over the past 5 years, is to develop a wellness model instead of the medical model. We're focusing on prevention. We provide support groups for kids to give them an opportunity to talk about the issues in their lives. We provide support through LYRIC for gay, lesbian, bi, transgender, and questioning youth. We have a foster youth service. When it comes to kids who live in group homes, what they've been through is horrific, and they have very special needs. Next year Albert is going to be helping us a lot with professional development. We've also had professional development from Al DeRaineri, Medical Director of CMHS Children's Services, and Janet Schalwitz, Medical Director of Child and Maternal Health in DPH.

Mr. Shipley: How much time do they get for training? Ms. Bascom: Half a day a week for professional development, not all of it for mental health but for the whole child.

Mr. Blonsky: The nurses don't work in isolation. We're trying to build an interdisciplinary team. To the extent we have an interdisciplinary team, we serve the youngsters better.

Mr. Shipley: How culturally competent are these teams? A mental health consumer who becomes a peer counselor can talk to another mental health consumer easily because they have a common bond. If you have a white Republican school teacher who's been in the system 25 years and is getting up there in terms of age and getting burnt out, how is that teacher going to relate to an African American middle school child who has never been around that social class?

Ms. Chou: The interesting thing about San Francisco is that this is San Francisco. People are exposed to multi-lingual and multicultural diversity all the time. If you have worked in the San Francisco School District 25 years and you're not sensitized culturally there's something very wrong.

I'm Asian, but at Galileo, I don't hang out with Chinese kids, but with African American students and Latinos. I love sports, so I hang out with the jocks and spend time with them. This is a district where people are very sensitized. When I hired teachers as a principal, I asked why do you want to come here. Most of them say, the diversity, they are tired of working with just one group, but want to work with a range of different kids. There are always exceptions, but I'd say the vast majority are very comfortable working with diverse populations.

Ms. Traveler: I want to say thank you for the presentation. I spent 35 years working in education in San Jose. In San Jose we only have 2 nurses for the entire district. It's horrendous. When I see the kinds of programs we have here in San Francisco, I can tell you this is quite amazing. It makes me feel good to sit here and hear this presentation.

Ms. Chou: Most of the schools are using supplemental money to provide mental health and emotional counseling for at risk children. So these counselors have a much lower caseload.

Ms. Traveler: I want to ask about this pyramid. Would you agree that in the last ten years, we are seeing children who do not have health insurance, children who do not receive any attention, and we have a number of crack children. What's the rationalization of coming down to 5% of money for treatment? I'm not so sure that's a good plan.

Mr. Walteros: You just mentioned the crack babies, which has been a major epidemic in San Francisco. San Francisco General Hospital was one of the premier places in the United States for dealing with these children. But if you place that child in an optimal environment, a foster home that is specialized, and special school programs where the teachers are trained to work with them, then those children later show much less damage, and so they will do their best. The research shows if you create an optimal environment then that child will do quite well. But if you take a child out for treatment sessions, and then put the child back in an ordinary classroom, the child will not do so well. We need to create an optimal environment all around that child. We need to focus on what we can do to create success for the child.

I'm not saying do away with treatment, but we currently have the pyramid upside down. Diane Scarritt, of Bayview Hunters Point, said she's seen three generations of children lost to crack and violence, and what we need is social activism. If you are going to work in the community, you need to have more than just object relations to offer; it's about social activism. In the Mission where I work, the gang element is my concern.

That's one of the things I have to deal with, not just strictly-defined mental health issues.

Mr. Villalba: Teachers have an incredible influence on our lives. The teachers can really become mentors. That's a very powerful influence for many of us. I read a report by Dr. Goldman at San Francisco Jewish Family Services. They tested a strength model. The findings were quite good, focusing on helping to support the teachers.

Mr. Walteros: The research is there. This is a model of relationship-based prevention. And the teacher is key in the well being of the child. We need to provide support for the teachers. However, we are putting the money somewhere else. I was in Sacramento with Sai-Ling promoting the consultation model. An 80-year old woman raised her hand and said she wrote a book about this in the 50's. So this is not something new. But it's thanks to Sai-Ling's leadership that it has come to the fore.

Ms. France: I would like to get a map of the services, and the ethnic background of the staff. I do see that the system is changing again and that there is an opportunity to follow children back to their neighborhoods and provide new programs like sports building and community building. I would like to know how kids in foster care are handled, also at-risk children, young men who have been incarcerated, young women who are pregnant or teen parents.

Ms. Bascom: With regard to teen parenting and pregnancy, we've been working at Hilltop School providing support and helping the teens do problem solving on the choices they need to make. A team of these teens in turn go out and make presentations at middle schools to other teens. Seventy-three percent of our San Francisco students have not had intercourse by the time they leave high school. We work hard to make that the norm. Out of the 6 teens on this presentation team initially, 4 have gone on to higher education, and they were the first in their families to do so.

With regard to young men who are incarcerated, we are not doing great, but we are beginning to work in that area.

Part of the Safe School Healthy Students Initiative, is being part of an interagency action committee, where we are working with Juvenile Justice. We're looking at doing data sharing to make coordinated transition plans so young people coming back to school after being in Juvenile Hall don't just show up unexpectedly. We're doing the same with the McAuley adolescent inpatient unit. We want to have coordinated transition plans.

With regard to foster youth, we've been working with the Juvenile Court Commissioners in coordinating services of students who are in group homes. This project is just starting. We just hired a coordinator last November. There are 120 youth in the case load. Their aggregate grade point doesn't even come up to 1.0. So this is a critical group.

The Board of the San Francisco Unified School District passed a resolution saying all District staff would be trained in working with sexual minority youth. We've done inservices at all elementary and middle schools. We're scheduled to do the high schools in November. We have a designated person at each school to provide answers to any questions students have in this area. We do professional development with those resource people 5 times a year, plus an additional 8-hour training each year.

Mr. Villalba: I think the Board should know the amount of money we're talking about in terms of services being provided, and where it comes from—from the schools, the mental health budgets, and the private sector.

Dr. Moses: I strongly agree with my colleague, Mr. Shipley, about his questions about cultural competency and continuing education, and if you don't have it, it might be good to have continuing education.

Ms. Chou: We do inservices on cultural competency. We are not naive enough to start sending people into strange territories without training.

Dr. Beauford: From the parents' perspectives, and that of many groups we've talked to, one of the main concerns they have is what happens after kids have their IEP's. Many parents are having a terribly difficult time with the follow up, with getting the services.

Is there any way the School District or CMHS could provide more information to parents about the IEP's, including the whole process and the resources available.

I hope there will continue to be ongoing dialogue between the School District and CMHS. This is something that will really help facilitate the services for students and parents.

4. REPORT OF DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES

Ms. Wang: I'll be reporting tonight for Nancy Presson, the Acting Director. The City budget is completed. Mental health, with your help and the help of the Coalition on Homelessness, fared better than in past years. We got a number of add backs which will open up treatment positions and will allow us to fund the Single Standard of Care. We'll also be able keep some Civil services positions open.

Some of you were involved in our first meeting on family involvement for adult services with Tina Yee and myself. There are some things it looks like we can do this year and some things will be a long term project. Under long term goals are included changing our CMHS culture and changing attitudes toward families.

Short term we're looking at why it's necessary for a client to have to sign a release at every stop in the system. I think there's a way we can figure out how to make that simpler. There are training issues we want to look at, and we can use your help with those. But we also want to follow up after training so staff can really put this new perspective into practice. We are very interested in trying to develop a better response to families who are struggling with very difficult issues with loved ones.

We also are about to start an abbreviated planning process on the Steinberg funding, AB 2034, which is for mentally ill homeless who have contact with the criminal justice system. A number of different departments and agencies would likely need to be involved. Part of the plan would be providing services for families who are taking care of loved ones in the home. This is one of the few opportunities we've had for additional state funding. We're going to do our very best to access that money.

In the past decade since the Loma Prieta earthquake, we've gradually built an emergency response system. This includes responding to major disasters, hotel fires, and shootings people witness. DPH quite some time ago made a very strong statement that violence is a public health issue, not just a police issue. With the recent shootings, with kids getting killed in the Bayview, there were a number of ministers who called the question and tried to bring kids together to try to stop the violence from continuing. As part of that process CMHS has joined in to work on thinking more proactively. LaDonnis Elston is very much a part of that planning process. They are midway, so there is nothing to report yet. But it is a very positive approach.

The Police Department is doing an emergency drill next week, involving something similar to the situation a Columbine High School. In this simulation, a school will be taken hostage. This is an interdepartmental effort between the Police Department, the School District, DPH, and CMHS.

Dr. Moses: I've been to two of the meetings on preventing violence in the Bayview Hunters Point area, and there were people from DPH and it was a very good thing.

Ms. Wang: Last month you discussed the capacity issue. This is a question we've been struggling with for quite some time. It's not a new issue, but it continues to be a pressing issue. The Quality Management division of CMHS, took it on as a project. They started working on this about a year ago. I've asked Kevin McGirr, from Quality Management, to make a report as a follow up to your last meeting.

Ms. Deger: Are any of the Centers frozen in terms of taking new intakes?
Ms. Wang: Yes. Some Centers have staff positions that are frozen. And some Centers lose their interns at the end of the school year, so they can't take as many clients. Also we have to take people from inpatient services into outpatient programs as a priority, and so can't always absorb people from the community right away. Right now South of Market Mental Health Services is closed. They have a very heavy case load. Also the OMI Clinic is closed. They have had significant air quality issues there, and have had to relocate the staff to other centers. As a result they can't take new clients.

Ms. Deger: Is there a plan in place to solve the problem of clinic closures? Ms. Wang: We're doing some planning to try to deal with this on a long term basis. First we're going to review our access system. You heard at your last meeting some of the criticisms of the access system.

Second, we'll be reviewing our adult outpatient system, because we've had capacity problems for a good long time. We're hoping to work out a better approach.

Mr. Villalba: I'm interested in how CMHS evaluates the private practitioners apart from the initial evaluation. Ms. Wang: First, they're all credentialed. So that's the first step, to make sure that that's in place. They are also under our grievance procedures so clients can file grievances on private practitioners as well as other programs and clinics.

Mr. McGirr: We have over 400 individual providers in our network. This year we're interviewing a sampling of private practitioners, looking at their charts, reviewing their billing, and the kind of care they provide. When the initial authorization for treatment has expired, the provider is required to send in a treatment plan. They won't get paid unless the services are authorized, so they have an incentive to provide those plans.

With regard to the question of capacity, I've brought handouts. The first one shows admission data for the first 5 months of this year as compared with the first 5 months of last year, for each of the outpatient programs. Some programs admitted new clients, some did not. The bottom line is that for that 5-month period, we've admitted 438 fewer clients this year than last.

On the single page handout, you'll see the break down of clients, with summary of totals by ages—children's services, adult services, and geriatric services.

I think this final handout, the Service Capacity Assessment Report, is the most informative. The State requires that we analyze capacity. It's an analysis of the total number of clients we've been serving over the last 5 years. There's been an increase of 27% over the past 5 years. CMHS has seen over 22,000 unduplicated clients over past fiscal year.

We also have looked at how clients are accessing our system, including clients who are brand new to the system, and those who are brand new to a particular program, but not new to the drsystem. We wanted to see how clients are moving through the system. Are they being served appropriately? Are we reducing acute services?

Service intensity is something we define as the number of hours a client gets on a monthly basis. The service intensity over the past 5 years has gone up for adult services, up and down for children's, and down for geriatric services.

We also looked at how we are managing clients who are using our most acute services, specifically hospitals. We've been focusing on providing services in the community rather than through hospitalization. There is good news here. Looking at clients who have been hospitalized the percentage who have been hospitalized 3 or more times within a year has gone down from 35% to 29%. So we're moving in the right direction.

The number of new clients coming into the system is declining. This may mean that the population of clients is stabilizing now 2 years after the implementation of managed care.

With regard to conclusions, the data we have do not give us a precise measure or record of unmet service demand.

The delay in the submission of claims data by the Private Practitioner Network may contribute to an undercount of new clients.

While new systems clients have decreased, many programs are in fact admitting new client referrals from other programs. We hope this means that clients are moving to more appropriate care, thereby reducing recidivism.

Dr. Beauford: Because the meeting has run so late, I'd like to ask you to interrupt your report at this point. I apologize for cutting you off. Maybe we can have time to digest it and submit questions for our next meeting.

Mr. McGirr: I'd be glad to come back.

Mr. Villalba: I do think it's wonderful to have an in depth presentation. This detailed report is superb.

Dr. Beauford: This is the exact thing that we asked for. Thank you.

5. REPORT OF THE EXECUTIVE DIRECTOR

Ms. Brooke made a brief announcement about upcoming program reviews and explained that the Police Crisis Intervention Program is dealing with a problem about whether the police training will be 20 hours or 40 hours.

6. STATE LIAISON

Mr. Shipley handed out information about the Governor's budget break down on mental health services and announced the Region IX consumer/survivor/client meeting on August 1st in San Francisco.

7. COMMITTEE REPORTS

Executive Committee:

RESOLUTION (MHB-00-25): Be it resolved that the Mental Health Board place the following ad in the Street Sheet in appreciation of the work of the Coalition on Homelessness:

The Mental Health Board
says Thank You
to the Coalition on Homelessness!

We so much appreciate your dedicated advocacy for mental health services for homeless and other underserved people. This year's budget is a victory, especially for the Single Standard of Care. Thank you for the key difference you made!

(Passed)

RESOLUTION (MHB-00-26): Be it resolved that the Mental Health Board present its first ever Lifetime Achievement Award to Supervisor Sue Bierman for her years of championing mental health services in San Francisco, to read as follows:

The Mental Health Board of San Francisco
presents its very first
Lifetime Achievement Award
to
Supervisor Sue Bierman
For making mental health services your top priority in budget negotiations,
and for your unfailing commitment to serving the people of San Francisco,
especially those most in need.
We are so proud to have you on our Board,
and are so thankful for our partnership with you.
We will keep you in our hearts always.

(Passed)

The Board also decided to send flowers with the award.

8. PUBLIC COMMENT

Mr. Kalman questioned whether the Board was following the requirements of the Sunshine Ordinance with regard to the public being able to ask questions at Board meetings. It was explained that the Board is in complete compliance with the Sunshine Ordinance by calling for public comment before any resolution is voted on.

Ms. Coleman: I came here all the way from Santa Rosa to see what your Board is like, and it's refreshing and I commend you guys.

Dr. Moses: Every time we have a presentation, the presenters just leave at the end and there is no follow up. I'd like to bring it to your attention that we need to schedule 5-10 minutes after each presentation for Board members to discuss what we've learned.

Mr. Villalba: I agree. Our presentations are getting more comprehensive, and we are getting very good people for the presentations. It really is a tight schedule to get everything done by 8:30. Maybe we need to extend the Board meeting by 15 minutes.

Dr. Beauford: I'll take those recommendations to the Executive Committee.

9. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:53 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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Cancelled

MEETING OF THE FULL BOARD

~~Wednesday, August 9, 2000~~
~~1380 Howard, Room 537~~
~~6:30 p.m.~~

CANCELED

There will be no meeting of the Mental Health Board on August 9, 2000. However the minutes of the meeting of July 12, 2000, are enclosed with this mailing.

The next meeting of the Mental Health Board will take place on Wednesday evening, September 13, 2000, at 6:30 p.m. in Room 537 at 1380 Howard Street.

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MEETING OF THE FULL BOARD

Wednesday, September 13, 2000
1380 Howard, Room 537
6:30 p.m.

AGENDA:

1. **CALL TO ORDER, INTRODUCTIONS** 5 minutes

2. **CONSENT CALENDAR** See Attachment A 5 minutes
   a. PROPOSED ACTION: The Board approves July minutes
   b. PROPOSED ACTION: The Board approves leaves of absence for September

3. **PRESENTATION: DPH and CMHS Prevention Strategy** 45 minutes
Barbara Garcia, Director of Population Health and Prevention, will present strategies for prevention in the upcoming year.

4. **REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES** 30 minutes

5. **REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD** 5 minutes

6. **REPORT FROM MHB STATE LIAISON** 5 minutes

7. **COMMITTEE REPORTS** 15 minutes
   - Executive Committee, Chair's Report
   - Additional committee reports as needed

8. **PUBLIC COMMENT PERIOD** 10 minutes

9. **ADJOURNMENT**

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health

NOTE: The minutes for the July 12th meeting were sent out in August.

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MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Down-town Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

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MENTAL HEALTH BOARD
ATTACHMENT A
September 13, 2000

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed.

A. Approve Minutes of Prior Board Meeting

RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of July 12, 2000, be approved as submitted.

B. Approve Requested Leaves of Absence
Additional requests may be added at the Board meeting.

RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of September 13, 2000, to the following members: Mickey Shipley.

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MENTAL HEALTH BOARD OF SAN FRANCISCO

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UNADOPTED MINUTES

Wednesday, September 13, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Jim Beauford, Ph.D. (Chair); Tim Agar; Scott Ruble representing Supervisor Sue Bierman; Bridgett Brown; April Martin Chartrand; Andrea Leung, L.C.S.W., A.C.S.W.; Lora Traveler.

BOARD MEMBERS ON LEAVE: Renee Deger; Marushka France; Pat Harrison; Brian Peagler; Mickey Shipley.

BOARD MEMBERS ABSENT: Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Chet Villalba; Barbara Williams.

PRESENTER: Barbara A. Garcia, Director, Population Health & Prevention, Department of Public Health

OTHERS PRESENT: Bill McConnell (CMHS); Marion A. Keller, L.C.S.W.; Mike Wise (San Francisco Network of Mental Health Clients); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Jim Beauford, Chair, at 6:45 p.m.

2. CONSENT CALENDAR

RESOLUTION (MHB-00-27): Be it resolved that the minutes of the Mental Health Board meeting of July 12, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-28): Be it resolved that the Mental Health Board grant leaves of absence for the September 13, 2000, meeting to: Renee Deger, Marushka France, Brian Peagler, and Mickey Shipley. (Passed)

3. PRESENTATION: DPH and CMHS Prevention Strategy

Ms. Garcia: I have been with the San Francisco Department of Public Health for about 4 years. But I'm familiar with the area, since I worked for about twenty years in the Santa Cruz County area, including with rural farm workers. I worked at a consumer-based health center, where 51% of the Board members were consumers. I have a lot of background on the issues of consumer input and community focus.

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Ms. Garcia then distributed a handout on Population Health and Prevention and reviewed it as follows:

FUNCTIONS OF POPULATION HEALTH AND PREVENTION

- Employ a systematic approach to identify the health conditions and needs of communities.

- Determine priorities, and develop policies and programs that address the health conditions and needs of communities.

- Assure that quality health resources and services are available to all San Francisco communities.

We take a systematic approach to health and have 72 advisory committees in the Department to get community input. The priorities you have set for the Mental Health Board are in line with the rest of the Department.

GUIDING PRINCIPLES

- Focus on community health
- Responsiveness to community needs
- Collaboration with communities and emphasis on community strengths
- Emphasis on promotion of health and prevention of injury and disease
- Commitment to cultural competence
- Dedication to social justice

It's clear that social justice issues can influence the status of people's health.

PROGRAMS AND SERVICES

- Performs prevention, control and surveillance of communicable diseases and monitors the health status of the population through epidemiology and research.

- Enforces regulations including Environmental Health, Occupational Safety & Health, and Emergency Medical Services.

- Ensures delivery of community based services including, mental health, substance abuse, HIV/AIDS, housing, and maternal and child health services.

- Responsible for health promotion and disease and injury prevention, including, HIV Prevention, Women's Health, Tobacco Control, Refugee Health, and Lead Prevention.

- Contracts with community-based organizations total approximately $200 million

For many of the contractors we fund, we provide 80-90% of their funding, which means that when they're in trouble, we're in trouble. So we try to make sure they are doing well. We provide technical assistance and work to develop a strong partnership with the contractors.

This year the Department is focusing on thinking organizationally rather than program by program. We want all the sections of DPH which provide funding to organizations to do so in a coordinated way. We are currently doing a pilot of this with four of the major organization we fund to see if there is a better way to provide support.

Funding deficits will continue to be an issue in the coming year because of the continuing decline in federal funding. We're going to be looking at how we can keep people out of crisis. We are one of the few health departments with a housing department. We develop and support housing. Appropriate housing is very effective in providing the stability that many of our clients need to maintain a healthy status.

This year we were faced with the equivalent of a $42 million deficit, which is equal to the whole budget of Substance Abuse services. So it's very important that we have a city which is as supportive of public health as San Francisco is.

SUBSTANCE ABUSE SERVICES

Goal: To ensure services in a timely manner and reduce the harm associated with alcohol or drug use in San Francisco.

Strategies
- Increase existing services and develop new services
- System change
- Policy development

Initiatives

- Methadone expansion—methadone van and increased community capacity to provide methadone treatment

We have 17,000 injection drug users in San Francisco, but we only have treatment for 6,000. So 11,000 are going without treatment.

Moving toward harm reduction. Working on needle exchange to reduce hepatitis C.

- Office Based Opiate Addiction Treatment (OBOAT)—expand methadone treatment

We are developing policy around different models of care. Methadone, which is used for opiate addiction, can also be used for pain. Physicians are not allowed to prescribe it for addiction. If they want to do this, they have to get into a whole system of treatment. We are asking for a federal waiver to do a pilot program, to bring in physician-based care.

We are focusing on very complex cases. We just met with the head of the state narcotics bureau, and she was interested in what we are doing. Instead of taking people to jail, we get them into treatment and work with them from point of view that addiction is a medical issue rather than a criminal issue.

- Wound prevention care—provide prevention education and community based care

Last year San Francisco spent $18 million to treat people with soft tissue infections. This is the #1 diagnosis at the Emergency Room at San Francisco General Hospital. Black tar heroine is one of the leading causes of soft tissue infection and abscesses. You can see the scars these abscesses leave behind. This is a very painful reaction to drug abuse. We have created a special wound care program, which has reduced the need for hospitalization.

- Overdose Prevention—media campaign, provider and user education, CPR training in the jails

Of the deaths of homeless people, 80% are due to overdoses.

MENTAL HEALTH SERVICES

Goal: To provide San Francisco's uninsured and Medi-Cal beneficiaries with access to a high quality, effective, cost-efficient system of mental health care that is community-based, culturally-competent, and consumer-guided. Mental Health Services values strategies that promote wellness, avert crises, and maintain clients within their own communities whenever possible.

Strategies

- Increase access to care
- Increase community based alternatives to acute care
- Assure clients have access to the most effective medications
- Assure "high utilizer" clients have access to case management

Initiatives

- Single Standard of Care—increases access to uninsured, particularly the homeless
- New Acute Diversion Unit—alternative to acute care for some clients
- New Pharmacy Benefits Manager—assures access to medications
- Crisis linkage and case management initiatives that work with high utilizers:

    Crisis Resolution Team
    Mobile Outreach Support and Treatment Team (MOST)
    Mobile Crisis Team
    Assertive Community Treatment Teams

HOUSING

Goal: To develop and maintain a wide range of community-based housing options for homeless, low-income and disabled San Franciscans.

Strategies

- Expand safe and healthy housing options

- Consolidate housing efforts within DPH to maximize available housing resources

- Integrate the development of housing funding streams to facilitate the development of mixed population housing versus single population housing driven by categorical funding sources

Initiatives

- Redesign and expand Emergency Housing/Respite

- Supportive housing for homeless seniors

- Housing Program to provide stabilization services following discharge from SFGH Department of Psychiatry

- Transitional housing for homeless LGBTQQ Young Adults

Mark Trotz, Housing Director for DPH, has been very creative in blending funding, to make programs meet the needs of our clients.

DPH is developing new ways to negotiate with neighborhoods about siting new projects. Every neighborhood I go to feels they are more burdened with social services than other neighborhoods. This issue will become even more important with district elections.

INTEGRATION

Initiatives

- Behavioral health planning—integration of substance abuse and mental health services

- Dual diagnosis policy and implementation

One of first steps we took was to develop a dual diagnosis policy and implementation plan. When I was director of Substance Abuse Services. Jo Ruffin, Director of CMHS, and I agreed to a policy. We've been challenging both sides of the system to improve coordination.

- Homeless services/outreach

We're doing a lot of work in this area. The MAP Van was originally started to help bring public inebriates off the street and into detox and other treatment. In the meantime, it has become a transportation system for the homeless. We're trying to move it back to its original purpose. We have developed a curriculum we'll be putting the drivers through. We're working on coordination between the MOST Team and the Tom Waddell Clinic.

- Shelter system redesign

It's important to go back to our shelters and see if they meet the needs of the clients or can they do more. I think they can do more. There are literally hundreds of people involved in the shelter redesign discussion. We have 1,400 shelter beds between North, South, Episcopal Sanctuary, Men's Place, Women's Place, and Mission. Since DHS manages these shelters, they have always felt DPH has not done enough for them, so we are engaged in discussions about having a stronger presence in the shelters.

- Primary care planning

DPH has been involved in the past 6 months in a strategic planning process. The major advisory boards are needing to have more coordination and communication. We've been working to have cross council discussions.

In the next three months we will be focusing on the budget for the next fiscal year. We'll be looking to you for what kinds of priorities and issues you'd like to see in our budget planning. We take your recommendations seriously.

Mr. Wise: I've been involved in a minor degree on the Police Crisis Intervention Project. I'd like to know your perspective on the development of this curriculum.

Ms. Garcia: What I did was to pull together everyone working with the police on different health issues, including overdose prevention, restaurants, and mental health. How do we train police officers in the multiple issues they face every day? I think we are going to see barriers. We have to think, what's the most effective way for these officers to do their job. They are 24/7 outreach workers and the more knowledge they have the better.

Institutional history is always remembered. The police officers told us that we used to have this program, then we cut it, and now we're trying to bring it back. And that's true, we did cut it due to budget issues. So we have to re-build trust. And then there is the issue of training the officers on multiple issues. Also the process changes with new Chiefs and new emphases. I would imagine the police officers look to these trainings to help them do their jobs. I think we'll just have to be tenacious about this. It's a hard struggle to do system change and system integration, but we need to just keep with it.

Ms. Traveler: Thank you for a great presentation, you're like a dynamo. Is heroin still the most used drug in San Francisco?

Ms. Garcia: Yes. Alcohol is the number one killer, but heroin is first among drugs. Then there are the new drugs like ecstasy. Mixing some of these with alcohol can kill people. Heroin purity has gone up and the cost has gone down, so it's an increasing problem.

We are looking forward to medications to treat cocaine and opiate abuse in next 5 years. Meanwhile residential and other types of treatment have been very effective.

Ms. Traveler asked about funding. Ms. Garcia: We get substance abuse block grant dollars. One of the issues we have to look at each year is what kind of federal cuts are coming. Ryan White is on the table. We're facing cuts. San Francisco was an epicenter of the AIDS epidemic. Now we're facing a potential 10% cut. They are putting the money elsewhere. San Francisco wants to keep our system at the same level and increase the money for the rest of the country.

Ms. Brown: Is most housing for people temporary or permanent?

Ms. Garcia: We're more supportive of permanent housing. That's the foundation for the stabilization of clients. Most of our new initiatives in this next year will be around permanent housing. Every year around January we start hearing about freezes and cuts. We're focusing on reducing hospital costs. Mental Health created the model for the rest of the Department by cutting high-end use in favor of community-based treatment.

Ms. Leung asked about the hotline hotels.

Ms. Garcia: We're not getting $8 a night hotel rooms. They're not safe, so we don't want them. We're looking at a couple floors in a hotel that we would basically take over and manage. We have the same amount of money in our budget but the cost of hotel rooms has tripled. We're targeted this program to hospital discharges, and SFGH has the priority. We're talking about not more than 30 rooms.

Mr. Agar: You were talking about organizations that receive multi-contract funding. Which four are under review?

Ms. Garcia: One program we have just reviewed is the Bayview Hunters Point Foundation. When I brought the managers of programs together I asked, "Do you all communicate?" The answer was no. "Do you all know each other? Again the answer was no. We're looking at this issue from provider perspective. One program said they had 5 monitors come out in one day, and none of them knew about each other. We need to be coordinated and more effective than that.

Mr. Agar: Is the program for Sexually Transmitted Diseases under you? Ms. Garcia: Both Mitch Katz and I manage that program. Mitch is Medical Director for those programs and I do the administrative management. STD's, TB, and health and safety are all part of our division.

Mr. Agar: I think we might be at the stage where we need to pull STD and AIDS back together. Ms. Garcia: The feds are wanting to do that with STD, AIDS, and TB.

Mr. Agar: How adequate is the current level of the Single Point of Responsibility Programs for the target population, There's currently a total of 400 clients in the SPR's. is there a need for more SPR programs? The payoff seems big and clients are getting help.

Ms. Garcia: The evaluation is clear. These programs are producing cost savings and things are better for the clients. The theme this next year is how do we build more community-based services. We need more, and it's going to be a real challenge.

Mr. Agar: What would be an ideal number of clients in SPR's? 1000?

Dr. McConnell: We're in the process of looking at those teams. One school of thought says people should stay there forever. We're thinking about capitating them differently and increasing capacity in the ones we have now.

Mr. Agar: I have a concern about case loads getting too high.

Ms. Garcia: Yes, we can't let that happen. We have to keep the case loads small enough for the programs to be effective. Dr. McConnell: Yes, we wouldn't add on unless the current cases were taking a lower level of time.

Ms. Garcia: That's going to be the challenge—how we're going to be able to create community programs.

Mr. Agar: What I'm reacting to is the word new. I think we need to rely on the community to convert services instead of creating new services.

Ms. Garcia: We're doing that. When I became director of Substance Abuse Services, I cut day treatment programs and converted those dollars to detox units. We're looking at the Ozanam Center 's detox work. We're connecting them with PES. Many of our services are brokered out to community-based services.

Mr. Ruble: Of the $200 million in community based contractors, how will that be affected by the minimum salary initiative?

Ms. Garcia: Most of them were doing okay with that particular initiative, but I'm concerned with the larger issue of salary, and helping nonprofits to retain qualified, culturally-competent staff, and keep their salaries at a level that can be managed. The nonprofits have trained people and then what often happens is that we hire them into our Civil Service programs. The efforts at unionizing nonprofits may have some impact on this.

Dr. Katz and I committed to not funding nonprofits for the reason that they are cheaper, but because they are effective, culturally-competent, and can deal with clients in a way we can't. In the future they will not be cheaper. They can't be.

Dr. Beauford: Thank you for your presentation. Ms. Garcia: I'll be glad to come back and meet with you on a quarterly basis and would like to work with you on your budget priorities.

Dr. Beauford: The Board would like to stay in communication with you. The Executive Committee and the Board feel it is really important to recognize and support outstanding individuals, and in that spirit we'd like to present you with the following award:

The Mental Health Board of San Francisco
presents this

Certificate of Gratitude
to
Barbara A. Garcia

For your steadfast commitment to treating the whole person,
for your administrative savvy in integrating services,
for your continuing dedication to community empowerment,
and for your unfailing commitment to diversity.
We are proud to honor you as one of the most effective and
best loved people in public health in San Francisco.

4. REPORT OF THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES

Dr. McConnell: I'm here for Nancy Presson this evening. Most of this report was written by her.

1. AB 2034—San Francisco Mental Health has submitted a letter to Steve Mayberg, Director of the California Department of Mental Health requesting an allocation to provide services to the homeless mentally ill. The proposal offers intensive case management services for 120 new individuals referred through PES, jails, and shelters. There are dollars set aside for a community outreach program and housing. Both of these programs would be awarded trough an RFP process.

Attached is the letter. We're pretty confident we'll get some of this funding.

2. MOST Team Expansion—Barbara Garcia and Nancy Presson have issued a letter supporting an expansion of the MOST Team at the South of Market Clinic to provide the case management program proposed for AB 2034 funds. The MOST Team has experience in engaging the homeless mentally ill. The South of Market Clinic is able to house the new program (most services will occur off site in the community) and there is City support for expediting the recruiting and hiring of positions.

Supportive housing and early intervention will be RFP'd so people can compete on those.

3. Crystal Springs, a skilled nursing facility operated by the County of San Mateo, is closing January 1. San Francisco has been a partner with San Mateo for slots in this facility for the elderly mentally ill since it started. We will be working with San Mateo to place the 7 clients currently in residence in other appropriate placements over the next few months.

4. Benchmarks—Bill McConnell has participated in a Department of Health effort to move in the direction of using benchmarks as part of the strategic planning process. The first step during this fiscal year will be for each of the major sections to report on measures for Access, Customer Service, Health, and Finance as part of a pilot project.

Benchmarking is a process of selecting someone like yourself who is recognized as doing an excellent job and measuring yourself against them. Or you can measure yourself against yourself over time. Or you can measure yourself against the findings in the literature. We want to move more in the direction of benchmarking to improve quality. We're going to do a pilot of this first. It's one of the things coming out of strategic planning.

5. Filipino Services—Advocates for mental health services for Filipinos in San Francisco met with Community Mental Health representatives and Barbara Garcia to express their concerns that services are not sufficient for this population. They were particularly concerned about family services. Mental Health will be following up on their requests.

6. San Francisco General Hospital—CMHS is working with the Psychiatry Department and SFGH administration to assure that the Program Measures established in the budget this year for psychiatric inpatient beds are met. The four objectives relate to length of stay, funding mix, diversion from PES, and serving San Francisco residents. The first month's data demonstrates that the system is on track. Placement after discharge remains a great challenge for our system.

7. Bridge Committee Placements—With the help of Liz Gray and her Long Term Care staff, the Bridge Committee at San Francisco General Hospital has successfully placed 7 patients who required neurobehavioral placement. These individuals have behavioral problems but their primary diagnosis and need is due to organic problems. This year the budget identified a Health Department fund to assist in the difficult task of placing these clients in appropriate care. This is a great accomplishment and the health Department is to be commended in dealing with a difficult issue that many other counties ignore.

8. Medical Director—We are in the process of conducting interviews for the Medical Director. Thanks to the Mental Health Board for participating in this process. We expect one additional interview and hope to make an offer by the end of the month.

Mitch Katz was at our Executive Committee meeting Monday. He's reviewed the candidates himself and feels there is a strong pool of people.

Mr. Ruble asked about the neurobehavioral issue. Dr. McConnell: These are people with brain damage, who then have behavior problems and are acting out. This is not a DSM diagnosis. So it's not clear who's supposed to take care of these patients. They end up in mental health because of their behavior. We put together a Bridge Committee to work on this. We could claim they are not our problem, but we're not doing that. We're trying to figure out how to help them. They have been kept in the hospital for long stays, which is very expensive.

5. REPORT OF THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD

Ms. Brooke: I want to publicly commend Rich. I feel I am a very, very fortunate executive director. I was able to go on vacation and get my daughter settled in to her first year of college, and visit my brothers in New York, and not have to worry about the Mental Health Board falling apart. I knew there was nothing Rich couldn't handle.

6. STATE LIAISON

Mr. Shipley, the MHB State Liaison, was doing a review of the mental health services in Monterey County and so was not in attendance.

7. COMMITTEE REPORTS

Executive Committee:

Dr. Beauford: This month the Executives are going to talk about our Annual Retreat. If you have ideas or suggestions for part of the agenda, pass them on to Helynna or Rich. We already have an infrastructure and model for the day.

Ms. Leung: Mental health services does not seem to be the priority in the community as everyone knows. A few friends of mine are bilingual, with experience working in the mental health community. They came here as students, finished school, worked for low pay, and devoted themselves to mental health and social services. But the federal Immigration Service has always put applications of people like this on low priority as compared to people with a high tech background. With those people, everything is paid for and the process happens fast. By contrast, a nonprofit agency can't pay for the fees, and a wait of 4-5 years. At the same time the law has come out that the employer will have to guarantee the person a return ticket to their country if they don't get residency status. A lot of community agencies have stopped hiring such people because of this liability. Is there anything we can do, to get across to the Immigration Service that our field needs bilingual and culturally-competent staff?

Ms. Traveler: I recommend that you utilize your legislators to help your friends. This is the kind of thing they need to know about, and I'll be glad to talk with you more about how to do that.

Dr. Beauford: Would the Chair of our Cultural Competency and Special Populations Committee be willing to talk with Andrea about what the Board might be able to do?
Mr. Agar: Yes.

Dr. Beauford: Tim raised the issue about the closing of the pharmacy at the end of November. He is suggesting having someone come talk to us about that since there is some urgency. We had already talked about another speaker for November.

Mr. Agar: The impact of the closing of the pharmacy on our mental health clients is going to be so significant that we need to be fully aware of the plan so we can respond to the people we represent. How can they be doing this? People are scared. The Pharmacy will close. Walgreen's has been awarded the contract.

Dr. Beauford: We could cut back on some other areas of the agenda, ask Nancy to bring someone to talk with us about the pharmacy issue during the Director's Report, and put the other items in a written report. Then we could have the scheduled speaker as well.

Ms. Chartrand: I remember last time they cut back the pharmacy, there was one story from the administration and a different story experienced by people out at the pharmacy itself. I would like to see something beyond the rhetoric.

Mr. Agar: Another thing that would be helpful would be to request from the pharmacy director a summary of the prescriptions they are writing for behavioral medications and mental health, and how many consumers that involves.

8. PUBLIC COMMENT

Ms. Keller: I have a question for anyone who feels he or she can answer it. Barbara Garcia talked about blended funding. I wonder if anyone can give a definition and explain it.

Mr. Agar: Blended funding is when an agency that receives multiple contract funding from multiple sources, not just one source, and is able to combine those funding streams to treat people.

Ms. Brooke: The focus is on being able to combine different sources of funding to treat the whole person, rather than just dealing with one issue at a time.

9. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:24 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE FULL BOARD

Wednesday, October 11, 2000
1380 Howard, Room 537
6:30 p.m.

AGENDA:

1. **CALL TO ORDER, INTRODUCTIONS**	5 minutes
2. **CONSENT CALENDAR** See Attachment A a. PROPOSED ACTION: The Board approves September minutes b. PROPOSED ACTION: The Board approves leaves of absence for October	5 minutes
3. **PRESENTATION: FAMILY MOSAIC PROGRAM** Gary Zomalt will present the successes and challenges of directing the Family Mosaic Program.	45 minutes
4. **REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES**	30 minutes
5. **REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD**	5 minutes
6. **REPORT FROM MHB STATE LIAISON**	5 minutes
7. **COMMITTEE REPORTS** • Executive Committee, Chair's Report • Additional committee reports as needed	15 minutes
8. **PUBLIC COMMENT PERIOD**	10 minutes
9. **ADJOURNMENT**	

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A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

MENTAL HEALTH BOARD
ATTACHMENT A
October 11, 2000

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed.

A. Approve Minutes of Prior Board Meeting

RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of September 13, 2000, be approved as submitted.

B. Approve Requested Leaves of Absence
Additional requests may be added at the Board meeting.

RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of October 11, 2000, to the following members: none.

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MENTAL HEALTH BOARD OF SAN FRANCISCO

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mhb@igc.org
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UNADOPTED MINUTES

Wednesday, October 11, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Chet Villalba (Acting Chair); Bridgett Brown; April Martin Chartrand; Peggy Gilleran, J.D.; Pat Harrison; Andrea Leung, L.C.S.W., A.C.S.W.; Toye Moses, Ph.D.; Mickey Shipley; Lora Traveler.

BOARD MEMBERS ON LEAVE: Jim Beauford, Ph.D. (Chair); Tim Agar; Scott Ruble representing Supervisor Sue Bierman; Renee Deger; Marushka France; Brian Peagler.

BOARD MEMBERS ABSENT: Barbara Williams

PRESENTERS:
Gary Zomalt, Ed.D., L.C.S.W., Executive Director, Family Mosaic Project and Assistant Director, Children, Youth & Family Section of Community Mental Health Services

OTHERS PRESENT: Jo Ruffin (Director, CMHS); Nancy Presson (Associate Director for Managed Care, CMHS); Sharon Kotabe, D.Pharm., (Director of Pharmaceutical Services, Department of Public Health); Mike Wise (San Francisco Network of Mental Health Clients); Emeric Kalman (Family Member); Viveca Jones; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Chet Villalba, Acting Chair, at 6:35 p.m.

Mr. Villalba: Nobody can do as good a job as Jim. He's a terrific Chair. He's in Sacramento today and so is unable to be at tonight's meeting.

We'd like to welcome Jo back. And we'd like to say thanks to Nancy for filling in over the past months. We're glad to have both of them here with us tonight. You can see that we're such a handful that it takes two big wigs to keep us under control.

2. CONSENT CALENDAR

RESOLUTION (MHB-00-29): Be it resolved that the minutes of the Mental Health Board meeting of September 13, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-30): Be it resolved that the Mental Health Board grant leaves of absence for the October 11, 2000, meeting to: Jim Beauford, Ph.D.; Tim Agar; Scott Ruble representing Supervisor Sue Bierman; Renee Deger; Marushka France; Brian Peagler. (Passed)

4. REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES (Part One)

(Note: Part of this agenda item was taken out of order so that the presenter would be able to get to her next meeting on time.)

Mr. Villalba: Part of the feedback we wanted tonight was about the pharmacy issue and how the process of having outside pharmacies, like Walgreen's, handle prescriptions is working for our patients.

Dr. Kotabe: Thank you for inviting me to attend your meeting. I am responsible for all pharmaceutical services in the Department of Public Health. I used to be responsible, prior to June, for the Community Health Network. As of June I took over pharmacy services for mental health as well.

As you know the pharmacy services for mental health are through a company called PBM, Pharmacy Benefits Management. PBM approves the claims that the pharmacies submit. The pharmacies bill PBM and they in turn bill the City.

On the primary care side, we've only had one pharmacy in the city for patients with no insurance, namely the outpatient pharmacy at San Francisco General Hospital. So we've had to ask patients who were seen at the 10-12 primary care clinics to come to SFGH if they wanted to get prescriptions from the City. Because we only have that one pharmacy and it's designed for a volume significantly less than the requests we get, we could not keep up. The number of clients we serve has continued to increase, and the number of homeless people has continued to increase. We could not keep up with the increased volume of prescriptions and had to ask patients to wait an average of 2-3 hours.

Given the situation this last fiscal year, the Department of Public Health put forward in their budget proposal a plan to change the way we provide prescriptions. The proposal involved developing a system like the one we have for mental health patients. That is to develop a contract with a pharmacy benefits management company. The Board of Supervisors and the Mayor approved that plan. An RFP went out in July, the proposals came back, and were evaluated by an independent panel. Six proposals were submitted. We've entered into negotiations with the company that scored the highest. We will be implementing the new plan on November 1st. The company with the highest score was PCN, Pharmaceutical Care Network. The contract hasn't been signed yet. But we are planning to start on November 1st.

We are developing a sheet of Frequently Asked Questions for our clients in order to answer all the concerns we have heard from them. The FAQ's will be distributed through SFGH and community clinics. The sheets are translated into 5 languages in addition to English.

Ms. Traveler: Thank you for your presentation, because this has really been a problem. What is the name of the pharmacy in this network? Dr. Kotabe: All of the stores are part of it. The 3 major chains in San Francisco are Rite Aid, Safeway, and Walgreen's. There are close to 100 stores in the network. There are also clinics associated with other organizations, like the pharmacy operated by St. Luke's Hospital.

Ms. Traveler: Does the contract require the pharmacists to go through special training in talking with people, especially mental health clients? It is difficult sometimes for some of the pharmacies and their staff. Dr. Kotabe: We don't specify any training per se. However, the pharmacists in the city have been serving the mental health clientele, so that shouldn't be anything new to them. We do have in the contract, performance monitors and quality assurance monitors. We have the right to say that any particular pharmacy is not performing up to our standards and we can terminate them from the contract.

Dr. Moses: I want to echo Lora's remarks. Thank you for this presentation. Perhaps the three chains can learn from Kaiser about patient education. Kaiser pharmacists will take time to explain to you the side effects. Maybe you should put emphasis on that, that they need to explain to the patients what the medication is all about.

Dr. Kotabe: It is a regulation in the state that a pharmacist must talk with a patient about any new medication and make sure they understand how to take it. Not all pharmacies are at the same level in how they implement this. The chains are working on developing the skills of the pharmacists. Long's Drugs has partnered with UCSF in developing patient education programs. Although Long's is not part of our network, UCSF is reaching out now to Rite Aid, Safeway, and Walgreen's.

Ms. Ruffin: This new contract is not the same one that covers mental health. But both contracts pretty much cover the same stores.

Dr. Kotabe: One of the concerns raised by physicians in primary care is to make sure that the network has enough stock to take care of patients' needs. Mr. Villalba: Since this new program starts in November, it might be helpful during the year for us to hear from you how the program is working. Dr. Kotabe: I'd be very glad to do that.

3. PRESENTATION: FAMILY MOSAIC PROJECT

Mr. Villalba: I'm very pleased now to introduce Gary Zomalt who the Children's Committee met last year on a site visit. And I just want to note that one of your best advocates is Toye Moses from our Board.

Dr. Zomalt: First, I'd like to thank the Board for inviting me to present tonight. And thank you for the strong support you have given the Family Mosaic Project. You have helped us weather many of the storms we have had to go through.

Most of you have already heard about our outcomes in terms of the reduction of hospitalization, incarceration, and residential placements. Tonight I want to talk with you about 1) our high-end services, 2) what initiatives have we put in place to reach kids before they reach the intensive care phase, and 3) health outcomes problems and barriers, and ask for your support.

For those of you who are not aware, Family Mosaic was started in 1990 to work with kids who were being dealt with by multiple agencies. There was little coordination and little care. So Family Mosaic was born to provide both coordination and care and to provide flexible approaches to treatment.

There are three phases to the history of Family Mosaic. In the first phase, it started out as a project funded by the Robert Wood Johnson Foundation. The second phase began in 1993 when Medi-Cal began funding services, and that's ongoing. The third phase is that Family Mosaic has become completely integrated into the Children's System of Care. It's seen as part of a wider array of services which children and families can access if lower levels of care don't meet their needs.

Our target population is kids who suffer from severe emotional or behavioral problems that put them at risk for out-of-home placement, or kids who are already in out-of-home placement. Studies of our outcomes have provided us with impressive numbers showing that we have been able to significantly reduce hospitalization, incarceration, and out-of-home placement.

Our partners in the Department of Human Services and Juvenile Probation have recommitted to this work. We all serve these kids together. We've planned a broad array of services for kids who need intensive care management services. We have a partnership between all the major child-serving city organizations and with community organizations, too, and because of this we are achieving better outcomes.

My director, Sai-Ling Chan-Sew, did look at the hospitalization rates for one quarter, June through September 1998, and then at the same period in 1999. There was a 46% reduction of hospitalization rates in that one year. We're definitely moving in the right direction.

We have 239 kids at Family Mosaic. Half are above age 13 and half below; 72% are male; 61% are African Americans; 17-18% are Latino; 10% are Caucasian; and the rest are Asian, other, and unknown. Most of the kids come from Bayview Hunters Point, Visitation Valley, the Tenderloin, and the Mission. But we take kids from anywhere in San Francisco.

Ms. Brown: How do you get referrals? Dr. Zomalt: We have liaisons with the Department of Human Services, Juvenile Probation, and Education, as well as getting referrals through Community Mental Health Services. We have a transition coordinator who consults with people on what level of care is right for the client and the family. If it is determined that Family Mosaic is the right place, she'll help them fill out the application and walk them through the process.

The target population is kids with serious emotional and behavioral problems which put the child at risk for out-of-home placement. They must be full-scope Medi-Cal beneficiaries. Medi-Cal must be paying the full share. The kids must be in the 3-18 age range, and a resident of San Francisco.

A number of members of this Mental Health Board were very active in giving us moral support last year when the state changed the aid codes, which caused us not to be able to admit a number of kids. Thankfully with all of our work, we were able to get that resolved.

Ms. Ruffin: For those of you who weren't around in 1990, one of the important things about Family Mosaic is that it was a pilot for managed care. So the State contracts with us under a capitated program for working with high-risk kids. San Francisco has historically had a high rate of out-of-home placement. So when Gary talks about the 46% reduction, this is with the most difficult of the most difficult of kids.

Mr. Villalba: Could you review a typical case and define intensive case management?

Dr. Zomalt: First of all clients really want us to help manage their care; they don't want us to get on their cases. So I don't use the term "Case management" anymore. Once a person is authorized to be in our program, a family advocate care manager is responsible for doing a comprehensive assessment, looking at the family and all the providers involved with the family.

We do a strength-based family-centered approach. We'll say, "You're having these problems now, but what did your life look like before you were having these problems?" Then we build on the strengths, and build alliances with the family and the care givers to empower them. We identify in the care plan not only the needs the family has, but the resources that will be needed. Some are traditional mental health resources, some of them are transportation, food, family therapy, or dance lessons.

We try to get the resources to the family just in time so they can become engaged in the healing process. We stay involved. We will be advocates for the family when they are hitting blocks in the system. Or we'll engage others to be advocates for the family. We are also needs-based, in that whatever the family needs to heal is what we try to provide. This is called wrap around, because it is a nontraditional approach to provide all the services the family needs.

Ms. Gilleran: Whenever I see a group that is doing well with very big challenges, I want to ask what is it that is working, what is the philosophy that you use?

Dr. Zomalt: We take a "power with" approach instead of a "power over" approach. Many providers get on the family's case, tell them what to do and if they don't do it, write them off. Ours is a very humble approach. It's an influence approach. We are not the only leaders. The family is the real source for bringing change. We get away from the question of who's in charge and focus on what we can do together. And the family really has the final vote. This is novel in the life of families when they have been disenfranchised for so long. This is often the first time they feel they have been listened to and heard.

Secondly, family involvement plays a key part in the success of this work. My director, Sai-Ling, is an exceptional leader. She has pushed through the Family Involvement Team. Many of these parents who now work as members of this team have been through Family Mosaic themselves. So they can go out and say, "It may not be perfect,

but if you hang in there things will get better." The Family Involvement Team has made a big difference. It provides a support group for Family Mosaic. Our FMP Advisory Board was mostly made up of providers, when I first came to the Project. Now its members are mostly kids and parents.

The "power with" model is very messy and riddled with all kinds of challenges. But it gives us a lot more credibility. The service comes with respect for the family and with care. I think that's what makes it work.

Ms. Jones: The population you're talking about is mostly single parent families, is that right? Dr. Zomalt: Yes. Ms. Jones: What about a situation where you have a single mother on her own and maybe three children, and one child is acting out violently on the street or is on drugs? And sometimes the parents are on drugs. What do you do?

Dr. Zomalt: Rarely do we run into families that are isolated. There is usually a boyfriend or significant other in background. There are grandparents, relatives, the priest, the rabbi, a host of people in the family's life trying to help.

Coordination is the hallmark of Family Mosaic. We go in and sit down with all the players and get them coordinated. The first thing is for the family to see what's going on. What we find is among all the people trying to help, there is something the family is not getting. Maybe the mom does not have the funds to get the child to the therapist. Sometimes we can send the therapist out to the home for a period of time. These are therapists who are different than traditional therapists. And they understand that family might look very different than the usual stereotype of a family.

We think there are probably about 1,000 kids in San Francisco who may need this kind of service. We believe Family Mosaic needs to move from being a pilot to developing more services of this type. We are now rolling out Project Impact. It will identify kids early on through a comprehensive study being done at the Youth Guidance Center. Project Impact funds ten slots at Family Mosaic, which are targeted at the juvenile justice population.

We've been rolling out the System of Care intensive management program. We provide thirty slots, and now have ten more slots being added.

We have been working in collaboration with the Department of Human Services. Collaboration is hard work, but we are working on rolling out SB 163 services. SB 163 allows us to take money we spend on foster care and out-of-home placement and use it to provide services to keep kids in their homes and in the community. We hope to provide 70 new slots under SB 163 funding.

We now have a mechanism called Therapeutic Behavioral Services. Prior to this the kid had to get to the intensive case management level before they'd get help. TBS is one-to-one service to help the child reduce the behavior that is leading them toward needing intensive case management. We can reach the kids much, much sooner through TBS. This program is a partnership between mental health and Edgewood Center for Children. I'm really pleased with this opportunity. It provides us with a meaningful

way to deal with those behaviors that cause kids to be considered for out-of-home placement.

For example, we currently have a kid who was acting out in school, and was suspended because he struck a teacher. Mom and dad were having problems, and dad left home. The kid struck his mother, so she was feeling he was out of control. She began asking for out-of-home placement.

This kid had a mental health history. We asked the mental health provider to refer this family to TBS. They went in and did a comprehensive behavior assessment. He went around and talked to all the significant people in this child's life, including the teacher and all the providers. They determined that the behavior could be dealt with through TBS. They got a great behavioral coach who worked with the kid and then with the mother and then the mother and father. And the results were remarkable. Mom said, "I was pissed with him and just wanted him out. But now I've learned alot from the TBS staff about how to handle my son. My husband and I have learned how what we do impacts our son." This kind of outcome is very rewarding.

One problem that has occurred for our families with the capitation contract is with medical care. When kids are enrolled in Family Mosaic, they are effectively enrolled in an HMO. Even though we do the assessment including a dentist and health care provider, the referrals are often not working. Providers are not admitting our clients into primary care. A letter has gone out to all the of the providers in the Community Health Network, that they should accept our Family Mosaic clients, but do not receive primary care there. The thing is we have not quite been able to make this work. But we are getting special support from San Francisco General; they are giving our clients special appointment times.

Sai-Ling has had a study done of the health outcomes of our kids. The average cost of Medi-Cal statewide is $1,200, for FMP clients it drops to $900. What we are looking at now is probably the fourth generation of Family Mosaic, where we will probably consider getting the funds for primary care as well mental health services, and then we will network with providers who will work closely in partnership with us. It seems like the next logical step. I really ask for your support and input on this.

Mr. Villalba: It's confusing to me. Don't your clients get Medi-Cal? Dr. Zomalt: They do; they have to have Medi-Cal.

Ms. Presson: It's actually a computer systems problem. Children enrolled in Family Mosaic meet the eligibility requirements for Medi-Cal. Theoretically they get all their mental health services through FMP, and they should be able to get all their primary care through other providers. But the state computer system only has one slot for an HMO and they put Family Mosaic in there. It doesn't show that Family Mosaic is a special program. So providers think the families are covered for primary care by FMP, but that's not the case. So it requires phone calls and providers do not want to make time consuming phone calls.

Mr. Villalba: That means really that your goal for comprehensive services for a family is

not possible under that kind of a set up. How can you extract medical needs from psychiatric needs? This leads to more fragmentation.

Dr. Moses: What about families who are not eligible for Medi-Cal? Dr. Zomalt: That's what Project Impact, the Children's System of Care, and SB 163 programs are for. Dr. Moses: Do you come across people like that? Dr. Zomalt: Yes, every day. Thanks to support from the administration, we have been able to add 10-12 treatment slots for them.

Ms. Traveler: Say you set up an appointment with a dentist for one of your clients. Someone takes him there. The kid says they are from FMP, and has a note from FMP. The provider says, "Sorry, I'm not taking the note," and the family has to leave. So all that work that went into getting the appointment has gone down the tubes. What are some of the things we can do to help on that? Dr. Zomalt: Our administrative team needs to come up with a plan and at some point Jo will be presenting you a proposal.

Ms. Ruffin: The contract with the state has about 2 more years to go. In the next negotiation, we may try to get a contract for all the care, including the physical health care. In the meantime, the staff are working with groups and know where some of the providers are who now understand the problem and will set up appointments. And at SFGH they have set aside special slots for FMP clients.

Mr. Shipley: If you have two years left on the contract, isn't there any way you can approach the state, like when they are doing their annual review, and ask them to attach an MOU to the contract that medical services will be provided?

Ms. Ruffin: That's what we would try to do. The question is whether there will be an opportunity to do that before the contract negotiations. FMP got set up before mental health managed care. This comprehensive plan is a different model than the carve out model, the main model in the state. There is a lot of staff turnover at the state level, so it's hard to keep people informed about the status of FMP. But what really gets their attention are the outcomes from FMP. They are realizing that it's important not to destroy Family Mosaic, but to support it and continue to learn from it. Even though the state hates to make exceptions.

Ms. Harrison: Since SFGH is one of your collaborators, and people have to get their monthly ID cards there, why not use those cards as a means of identifying your clients?

Dr. Zomalt: That's a good idea, Pat. You always have good ideas! Basically one of the things that I've enjoyed in my position is the emotional support from your Board and the spirit in which you have interacted with me and Family Mosaic. Your goodwill is important to us. I appreciate it and look forward to working with you in the future.

Mr. Villalba: As you know from our Annual Report we think the Family Mosaic is a wonderful program and you are wonderful director.

Dr. Moses: I wanted to say to Jo and Sai-Ling, I think you made the right choice by hiring Dr. Zomalt. I remember Supervisor Kennedy's hearing on Family Mosaic. I went there and FMP really inspired me to continue to work in mental health. Supervisor

Kennedy called for re-establishing an FMP Advisory Committee. I'm so glad Gary is there. Sai-Ling did a great job. We should be deeply involved so he doesn't get burnt out.

Ms. Ruffin: We owe you, Toye, a thank you for helping to propel the Advisory Board. It came out of a difficult situation and it has been very very helpful.

4. REPORT OF THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES (Part Two)

Ms. Ruffin: Thank you for the beautiful flowers! That's very nice of you! I want to thank Nancy for doing such a great job of filling in for me. I've asked her to continue to come with me to these meetings. And to continue providing the Director's Report.

I received a copy of your Annual Report when I was on leave and read it. It's one of the most impressive reports I've ever seen that have come out of the Board. And the way you chose to highlight the programs and tie that in with your recommendations was great. It made me very proud to be connected with you.

Ms. Presson: Thank you for the flowers! And I'm so happy Jo is back!

1. AB 2034—Last month we reported that San Francisco had submitted a proposal for $2.5 million dollars to serve the homeless mentally ill. The State asked us to come to an interview, which was stage two of the selection process, on September 27. The State interviewed 30 counties. Our experience with the interview was excellent and we heard some nice comments about our proposal afterwards.

Awards are anticipated by mid-October for a November 1 start date. In the meantime, our Department is working with the MOST team to post positions needed for the expansion.

2. City Position Recruitment—We are currently looking to fill about 100 vacancies. We're looking for clinicians with language skills and cultural competency experience.

Ms. Ruffin: Not all of the positions are from the anticipated state grant. Some of them are from the hiring freeze being lifted.

Dr. Moses: What has happened with Collins Munns' position? Ms. Presson: That position, Associate Director for the System of Care, was cut from the budget. In some ways it's a wonderful task to be able to hire, and yet in this job market, it's also very difficult.

3. California Endowment Initiative for Mental Health—The California Endowment has issued an announcement for a special mental health initiative. The foundation has allocated $10 million statewide for mental health programming. Individual agencies may apply for $400,000 for the three-year period. Collaborations among community agencies are eligible for up to $1 million for the three-year period. We are encouraging agencies to apply and looking forward to collaborating in projects and/or providing letters of support. CMHS is looking to submit a county proposal.

The proposals due by November 3rd, so next month we'll be able to tell you what was submitted.

4. Department of Public Health Strategic Plan—The draft of the Department of Public Health Strategic Plan is now available for review. The Plan records the input from the various community meetings including the sessions with the Mental Health Board and Tangerine Brigham which occurred last Spring. The draft is available on the DPH web site and copies are available in our office. The Department is planning to present the plan to the Health Commission the first meeting in December. During the first department budget meeting, it was agreed that budget requests must relate to the Strategic Plan. In this regard, it is critical that the recommendations reflect our priorities. Your input is very helpful in this regard.

5. Bayview Hunters Point Foundation—This agency is a large provider of mental health, substance abuse, and HIV services within the Population Health and Prevention (PHP) division of the Department of Public Health. Barbara Garcia, PHP Director, has worked with Karen Patterson, Executive Director of BVHP, over the past year with organizational consultants to strengthen this agency. There will be a Board of Supervisors Hearing on October 18th on the situation. There is a potential strike by staff starting October 17th. The Department will insure that key functions such as methadone dispensing are managed in the event of a strike.

The BVHP Foundation runs a number of programs, including a large clinic on 3rd Street and a clinic in the Tenderloin. It's a very important provider to us.

Ms. Brooke: Jim Beauford did a program review at the 3rd street program, and was extremely impressed. He interviewed four clients who were very happy with the services there. The problem is not enough staff. Somehow they need to get more staff.

Dr. Moses: What's your advice to us regarding this hearing? Ms. Presson: I think it is a labor issue. I'll check with Barbara Garcia to see if she has any advice about whether Board members need to be there or not.

6. San Francisco General Hospital—CMHS is working with the Psychiatry Department and SFGH administration to assure that the Program Measures established in the budget this year for psychiatry inpatient beds are met. The four objectives relate to length of stay, funding mix, diversion from Psychiatric Emergency Services, and serving San Francisco residents. The second month's data demonstrates that the system is on track. Placement after discharge remains a great challenge for our system. We purchased a couple of extra Napa beds. Every day Liz Gray our long-term care director is looking for long-term placements.

7. Huntington's Chorea—There have been five Huntington's Chorea patients in the SFGH psychiatric units over the past year. Patients suffering from this neurological disease often present with behavioral issues as their disease progresses which are difficult to manage in any of our settings. We are working together with the Department of Psychiatry to seek specialist consultation to assist with behavior and medication planning for this unique group of clients.

8. Adult and Older Adult Orientation to Community Mental Health Services—Our Quality Management section organized a very successful orientation to our Adult and Older Adult System of Care on September 27th in the Library. Over 220 individuals attended to hear descriptions of our mission, service delivery system, and access points. IN addition there was information on managing crisis, documentation requirements in our system, and the grievance and complaint process. The purple Orientation Manuals are available for Mental Health Board members.

9. October is the annual Children's Staff Conference, an opportunity to share successes and be updated on the children's system of care. Judge Katherine Feinstein is the keynote speaker.

Ms. Ruffin: With regard to the position of Medical Director of CMHS, we've made an offer to one of the candidates, and that person is making their decision. As soon as the decision is finalized, we will be sending out an announcement.

Dr. Moses: I want to emphasize cultural competency. I know Jo is committed to that. But in section 2 of the Director's report, it says, "We are actively seeking culturally diverse applicants with language skills." But it's more than just language sills.

Ms. Traveler: Yes, many African Americans feel that leaves them out.

5. REPORT OF THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD
Ms. Brooke: Fifteen program reviews have been completed. It was a tremendous effort, and I want to thank all the Board members who did reviews. We only did 9 last year and this year we did 15!

Sheriff Hennessey will be at the Program and Services Committee on October 24th.

Ms. Gilleran: I'd like to encourage lots of people to come to that meeting. If we want our presence to be strong, this would be a good place to show our strength.

Ms. Brooke: Through Renee and NAMI, a reporter from KRON TV called me about doing a series of 5-minute pieces on mental health. I talked with the Executive Committee and Jo and Nancy and got suggestions for programs to focus on. Rich did a brilliant job of turning these into scenarios for TV. We hope this will help shape the pieces that are broadcast.

I'd also like to make a totally nonpartisan request for everyone to vote in the upcoming election.

6. STATE LIAISON
Mr. Shipley: On September 22nd and 23rd, I attended in Sacramento a meeting of the California Association of Local Mental Health Boards and Commissions along with the Mental Health Planning Council. There was a presentation by Stephen Mayberg about the budget, which included: $130 million for community services; $55 million for AB 2034 programs; $25 million for supportive housing with integrated services; $15 million for Children's System of Care; $6 million for mobile crisis emergency response; $2 million for the older adult system of care; and $3 million for respite care.

A $7.9 million package of SAMHSA funding was turned down, which was a shame.

Lanterman-Petris-Short Reform and mental health courts are two key issues that will be before the legislature next year. The State is also looking at revising realignment.

The mental health directors are looking at realignment county by county. They are also looking at a system of care including older adults, adults, and children and linking them with transitional services.

7. COMMITTEE REPORTS

Executive Committee:

Mr. Villalba: At next month's Board meeting we will provide you with the ideas we've been working on for our Retreat.

> **RESOLUTION (MHB-00-31): Be it resolve that the Mental Health Board move its Annual Retreat from December 2, 2000, to January 27, 2001. (Passed.)**

Ms. Brooke: I want to express my appreciation to the Nikko Hotel. They did not bat an eye when I asked them about changing the date of the retreat. There will be no penalties or fees. I'm very appreciative of their help.

8. PUBLIC COMMENT

Mr. Kalman: How many pages is the draft report of the Strategic Plan? Mr. Shipley showed him a copy. Mr. Kalman: Will it come up for a review and discussion at the MHB?

Mr. Villalba: The Executive Committee will look at that issue at its next meeting. Mr. Shipley: This draft is a long way from the final version. This is just the first draft. We just started reviewing the draft today. Mr. Villalba: At the next Board meeting we can let you know what our plan of response is.

Mr. Shipley: Tangerine Brigham has promised that she will come back to meet with us if we'd like to invite her back. Anyone who wants a copy of the draft plan can get one from her. Ms. Brooke: Also Mickey has been actively involved on the Steering Committee for Strategic Planning. Mr. Shipley: I've been like the eyes and ears of the Mental Health Board on the Steering Committee.

Ms. Jones: I actually worked with Bayview Hunter's Point for the past 9 years. Just from my observation, it seems to be a very personal thing that's going on there. When big people came around, everyone acted one way, but when they left, everyone went back to scratching each other's eye out.

9. ADJOURNMENT

There being no further business, the meeting was adjourned at 8: 29 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE FULL BOARD

Wednesday, November 8, 2000
1380 Howard, Room 537
6:30 p.m.

AGENDA:

1. **CALL TO ORDER, INTRODUCTIONS** 5 minutes

2. **CONSENT CALENDAR** (See Attachment A) 5 minutes
   a. PROPOSED ACTION: The Board approves October minutes
   b. PROPOSED ACTION: The Board approves leaves of absence for November

3. **PRESENTATION: BAYVIEW HUNTERS POINT MENTAL HEALTH SERVICES** 45 minutes
   Debberra Burrell, Director of Mental Health Services at Bayview Hunters Point Mental Health Services will give a presentation about the clinic's services and community mental health needs in the Bayview community.

4. **REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES** 30 minutes

5. **REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD** 5 minutes

6. **REPORT FROM MHB STATE LIAISON** 5 minutes

7. **COMMITTEE REPORTS** 15 minutes
   - Executive Committee, Chair's Report (See Attachment B)
     1. PROPOSED ACTION: The Board certifies that it has reviewed the revised proposed block grant for Community Mental Health Services from the federal Substance Abuse and Mental Health Services Administration (SAMHSA).
   - Additional committee reports as needed

8. **PUBLIC COMMENT PERIOD** 10 minutes

9. **ADJOURNMENT**

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MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Down-town Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

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SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

MENTAL HEALTH BOARD
ATTACHMENT A
November 8, 2000

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed.

A. Approve Minutes of Prior Board Meeting

RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of October 11, 2000, be approved as submitted.

B. Approve Requested Leaves of Absence

Additional requests may be added at the Board meeting.

RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of November 8, 2000, to the following members: Renee Deger.

MENTAL HEALTH BOARD
ATTACHMENT B
November 8, 2000

SPECIAL INCREASE IN SAMHSA FUNDING

The federal government has made a significant increase in funding for SAMSHA grants nationwide for FY 00/01. Although we have already reviewed and endorsed the original grant at our meeting on June 14, 2000, there is a requirement that the Board review this new dollar amount as well.

RESOLUTION (MHB-xx-00)

Be it resolved that the Mental Health Board send a letter to Jo Ruffin, Director, Community Mental Health Services, stating that the Board has reviewed the special CMHS renewal proposal for the 2000/01 block grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), which includes an increase of $171,477 in one-time dollars and $672,290 in on-going dollars, and that the Board gives its full approval and support to this grant.

City and County of San Francisco
Department of Public Health
Population Health and Prevention
COMMUNITY MENTAL HEALTH SERVICES

Jo Ruffin, L.C.S.W.
Deputy Director
1380 Howard Street
San Francisco, CA 94103
(415) 255-3401

November 1, 2000

To: San Francisco Mental Health Board
Executive Committee

From: Jo Ruffin
Director, Community Mental Health Services

Re: Increase in SAMHSA Allocation

The State Department of Mental Health has issued a revised allocation letter for year 2000-2001 SAMHSA (Substance Abuse and Mental Health Services Administration Block Grant) funds. This revised allocation distributes $7.9 million Statewide due to an increase in funds from the Federal government to California as well as $2.015 million in one-time funding. The uses of these funds are to be used to provide integrated services to adults and older adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

San Francisco received $171,477 in one-time dollars and an additional $672,290 in on-going dollars. We must prepare an amended application to be submitted to the State Department of Mental Health by November 30. Part of the application is documentation that the Mental Health Board has reviewed the application.

The Board approved the original application in June. We would like to present the revision at the Mental Health Board meeting on November 8. According to your wishes, we could give members time to give input on the draft document for a period of time after the meeting.

I wanted to alert you to our anticipated use of these on-going dollars:

- Increased Mental Health Educator time. Jeanne Kwong has agreed to increase her hours from 60% to 100% increasing our prevention and education efforts in Tina Yee's Cultural Competence and Consumer Services Unit.
- Increase Data Entry capability. Our Quality Management system oversees the authorization of services and data entry into our system is the way we are able to coordinate care across programs.
- Increase Long Term Care Linkage capability. Our Long Term Care team triages placement and discharge from in-County and out-of-County subacute facilities including Napa State Hospital, the MHRF, Canyon Manor, a number of Crestwood facilities and Medical Hill. This increase helps assess and place clients who are in acute hospitals needing long term care and place clients in the community from long term care.
- New Filipino Family Therapist to outreach and serve the Filipino community through an enhancement of children's services in the outer Mission area.

- Additional nurse for CASARC (Child, Adolescent Sexual Abuse Resource Center) to assess children when sex abuse is a possible issue.
- Provide administrative assistance and supplies for implementation of the invoicing system. It provides greater accountability to the City from contractors by connecting payment more tightly to actual services rendered.
- Flexible funds to wrap services around clients, including housing, emergency food, etc.
- Enhancement of behavioral health services in primary care settings
- Increased MD time to assure that an appointment is available to clients leaving the hospital.

The one time dollars will enable CMHS to purchase cars to provide transport for the Mission clinic, OMI clinic and PES, replacing vehicles. These cars have high mileage and great repair costs. The one-time dollars will also allow us to purchase computers for city programs and contractors so that they can participate in the coordination of data to improve the system of care.

I hope that the application package will answer your questions about this expansion and look forward to discussing the projects with you at the November meeting.

DPH

MENTAL HEALTH BOARD OF SAN FRANCISCO

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
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UNADOPTED MINUTES

Wednesday, November 8, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Jim Beauford, Ph.D. (Chair); Tim Agar; April Martin Chartrand; Marushka France; Peggy Gilleran, J.D.; Pat Harrison; Toye Moses, Ph.D.; Mickey Shipley; Lora Traveler; Chet Villalba.

BOARD MEMBERS ON LEAVE: Scott Ruble representing Supervisor Sue Bierman; Renee Deger; Andrea Leung, L.C.S.W., A.C.S.W.

BOARD MEMBERS ABSENT: Bridgett Brown; Brian Peagler.

PRESENTER: Debberra Burrell, Director of Mental Health Services, Bay View Hunters Point Foundation.

OTHERS PRESENT: Jo Ruffin (CMHS); Nancy Presson (CMHS); Mike Wise (San Francisco Network of Mental Health Clients); Kathy Shook; Marion Keller, L.C.S.W.; Emeric Kalman (Family Member); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Jim Beauford, Chair, at 6:41 p.m., who announced that Barbara Williams has resigned from the Board.

2. CONSENT CALENDAR

RESOLUTION (MHB-00-32): Be it resolved that the minutes of the Mental Health Board meeting of October 11, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-33): Be it resolved that the Mental Health Board grant leaves of absence for the November 8, 2000, meeting to: Renee Deger, Andrea Leung. (Passed)

3. PRESENTATION:

Ms. Burrell: The Bayview Hunters Point (BVHP) Foundation is a big foundation that provides different services in different communities. The Foundation has been providing services for 30 years in the southeast area of San Francisco, and we also have services in the inner city and in the Tenderloin, both a clubhouse model and day treatment program. In addition, the Foundation provides legal services focusing on violence prevention and intervention, and focusing on youth to keep them out of criminal justice institutions.

We have an intervention team for people who have survived being victims of violent crime in our communities. A lot of our programs don't have big staff. In addition, we have a substance abuse program. A large portion of our focus in providing mental health services, involves combining the services we offer in order to link them and be more effective. The delivery of substance abuse and mental health services to patients who are considered to be dually diagnosed is one of our goals to work on this year. We want to provide an integrated model of service, even though the funding comes from different sources. We also provide services to HIV/AIDS homeless clients and have an HIV/AIDS component through our substance abuse program. One of the techniques CMHS has encouraged is intensive case management. We have that operating full scale in our Tenderloin program and in our Thunderseed Day treatment program.

Our 4301 Family Center links up and branches out to all the other programs. Some of the programs we run which many people don't know are run by BVHP, include the Tenderloin Outpatient Program, and the Bayview Clubhouse, located in the Tenderloin. Our AB 3632 school-based program is primarily in middle schools and high schools in the city. Our Health Care for the Homeless Project is located at 50 Ivy Street. We also run the Balboa Teen Clinic at Balboa High School. Thunderseed Day Treatment is located on Cesar Chavez Street.

Our focus is not only on providing treatment for clients who walk through the door with serious mental illness, but also on prevention. So for that reason, you'll notice that we are calling our mental health center a Family Center now, because our focus really is on family services, creating a family partnership to recognize and reduce some of the consequences of a family member having a mental illness, and so it doesn't become such a burden on one person. We provide support, such as having a therapist who goes to a child's school to make contact with a teacher to help that teacher know what's effective in working with that child.

We go into the classroom to help teachers with different scheduling and teaching strategies to help the kids tolerate being in the classroom better.

We're also looking at reducing mental health interventions at a higher level than outpatient clinics. Specifically this means reducing hospitalizations and out-of-home placements, and keeping clients out of criminal activities. We don't necessarily have the capacity to provide wrap around services for all our kids. The Family Mosaic Project does a lot of wrap around services. We don't have enough staff to be able to do that. But we are able to work collaboratively with programs which do offer wrap around.

We have a violence prevention program that works with girls. We have a youth program that's not part of our mental health services, but is designed to make young people more aware of how to stay out of criminal activities, and give them meaningful activities to be involved in. Last year that program had a violence prevention health fair in the community, and created PSA's and passed out T shirts. On the PSA's, these young people were talking about the dangers of gang involvement and drug involvement.

Another program that we are making some linkages with is a program called Women Against Violence (WAVE).

In our mental health program, we probably see about 300-400 children, adults, and adolescents in a year's time. In our Tenderloin Clinic, we see about 350 clients. In our two day treatments, it's about 75 clients each. We do all this with less than 150 people on staff.

Some of the difficulties we have had to face have had to do with just the rising competitive salaries in the Bay Area, not just in mental health, but in general. It's an employees market right now. Everybody's trying to hire somebody. People with specialized skills can get the money. Money is what we can't offer. We can offer a highly-rewarding experience working with a diversity of clients. But by and large a lot of the people who want to come in and work in mental health services have put a lot of money out for student loans and they have to pay those back. So after a few years of dedicated work when an offer of money comes along, they may well go with it.

We believe that what we do really works. Like any program that provides services for people who are experiencing trouble in their lives, sometimes those troubles get better, and sometimes they don't. That's true also without treatment. But we believe that by offering services we give people a much better chance. We have no shortage of people calling for our services. We also count it as a success that we have been able to expand the services we provide, and that the focus is not on illness, but on wellness, and we focus strongly on this. An area where we want to provide additional services is with women, especially around issues of parenting, child care, domestic violence and re-entry into the work force. We're also looking at how to involve consumers more in our services. We have a token economy in some of our programs.

The mural on one of our buildings on 3rd Street, was painted by a group called Precita Eyes, and some of the clients from our program did some of the art work. We want to do more of that. We want to encourage people to be more expressive of what they can do and want to do and where they can be recognized and appreciated.

We also encourage clients to take a leadership role, and to come back into a program and be peer counselors. We want to know more about how to involve clients better.

Dr. Beauford: You've been very creative in developing and providing services.

Dr. Moses: I want to commend you. I remember many years ago I went to have a site visit for the Mental Health Board at BVHP and the clients spoke so highly of the services and the staff. My question, and I don't know if this is fair to you, is what about acupuncture? BVHP is one of the few programs that uses acupuncture. How will you address that and convince my colleagues that acupuncture is effective?

Ms. Burrell: I know that our acupuncture services were not only good services that a lot of people requested and people liked those services, we also had an intention to expand our service options. We're trying to link acupuncture with the homeless program at 50 Ivy Street. Dr. Peterson who runs the substance abuse services for BVHP is the one whose program provides the acupuncture. If we were able to have the funding, I know we could get the interest from the community in increasing the program. I will take your questions back with me to the management team.

Ms. Harrison: I have a partial answer to that question. Speaking now as the Chair of the Treatment on Demand Council, BVHP has been talking to Treatment on Demand, and we've heard you. We are now going to be including alternative treatments in our funding.

Mr. Shipley: I'm concerned about the adolescents at the age of 14 being put into the adult outpatient services. I don't think 14 and 15 year olds are ready to be part of an adult population. They are still legally children and adolescents. They aren't in regular mental health services. I understand that you are an independent nonprofit, so you can set up your services the way you want, but I'm still concerned with that. Can you give me an explanation of why you do it that way?

Ms. Burrell: The provision of services gets hooked up with the funding. With the children's funding piece, we don't have a service unit designation just for adolescents. One of the things we're trying to do on 3rd Street in designating our Center as a Family Center is to dismiss some of that territorial response. We are working to integrate interventions for the family. I'm told that it will be a big job to try to find therapists who want to work with both adults and kids who are under 14. I'm a therapist myself and I work with clients in all those ages, and I'm thinking what are you talking about? It can be done. But we're working on being able to expand the services we offer in such a way that children are not isolated in one section, but are integrated into a system that works with their whole family.

Mr. Villalba: What is your total annual budget? Ms. Burrell: I can't tell you that, because the total budget is overseen by the Executive Director of BVHP. The total budget is a budget that provides funding for all the programs on the brochure. We get money both from Substance Abuse Services and Community Mental Health Services. We also get funding from the Mayor's Office of Criminal Justice, and the Wellness Foundation.

Ms. France: I'm very curious if there's information on how far you're falling short on being competitive on salaries, how long you've been able to retain people, and is there any incentive program to help people pay off student loans and such expenses?

Ms. Burrell: I've been at BVHP a year, and the therapists were finding that the positions under the City were coming open and we lost a lot of staff to those higher paid positions. We've hired new staff, and some of them have been recruited into jobs that pay more money. This year when we negotiated our contract, we tried to make it a priority to increase salaries. In the new contract, we can offer higher salaries, but they still won't match City salaries and Kaiser.

What we have to try to do is negotiate for more attractive salary options in our budget process. We don't have funding options through other organizations or the Foundation which we could use to build in incentives. We tried to build a salary scale as an incentive, but the only thing we were able to do is build a longevity bonus. Employees who have worked 3 years would get an additional $80 per month. But we don't want to reduce the services we are offering our clients in order to raise salaries. We hope that we'll be able to make some progress.

Ms. France: I wanted to ask more about the WAVE program. I'm wondering if there are highlights of programs you're not able to offer that would be helpful. What services would you like to see added at this point?

Ms. Burrell: When women know there is a safe place, where they can address some of their issues, then these women become empowered to the point where they take on a leadership role. We'd like to have more training in empowering consumers to take on a leadership role and feel good about what they're doing. This is one of the programs where there are only a few staff. The participants in the WAVE program and the girls in the VIP program and the youth service program, have learned a lot and have been a major source of disseminating information in the community.

Ms. Traveler: I just think you are to be commended with these wonderful programs. My question is, you have 150 people on staff, is that the total, or in each of the programs? Ms. Burrell: That's for all the programs together, and that includes the primary care staff, not the support staff.

Dr. Beauford: Any ideas about streamlining the paperwork or including more efficiencies? Ms. Burrell: There's not a day that goes by that the clinicians don't say, "If I just didn't have to do so much paperwork...." I had a conversation with a provider the other day, and we were talking about how useful it would be for us to think about expanding some of our budget to have more support services to take care of the paper work.

Ms. Gilleran: Specifically regarding the AB 3632 program, how many kids do you serve in a year? Ms. Burrell: I think we have about 40 individual clients in that program. The therapists actually go into the schools and work with those clients. These are children who have gone through the whole SED process. When a therapist works in the classroom, the services are also provided for other kids. The classrooms they work in are special education classrooms. Mr. Villalba: They are really counselors in the classroom.

Ms. Gilleran: Are they specially trained in mental health issues, as well as special education? Ms. Burrell: I don't know if they started out with training in special education, but the three clinicians on our staff have been doing this work for ten years, so they have great first hand training in the classroom working with the special education teachers. Ms. Gilleran: This is great. I find special education teachers are great people, but they don't really have training in working with SED kids. Ms. Burrell: In our program, we're supposed to help the kids overcome any kind of obstacle. The plans we develop for the kids have measurable goals, things that can actually be observed.

Mr. Kalman: I would like to bring to your attention that part of our mental and physical health is recreation. Do you have any programs with the Recreation and Park Department?

Ms. Burrell: I don't know if we have a program that has a title that identifies it that way, but the activities in some of the programs are arts and crafts and complete physical education. Our community offenders program is working with youth in the community to discourage them from criminal activity. They've put together basketball teams, one for boys and for girls. The boys team traveled all over the country and went to New Zealand and Australia. Also Martin Luther King School will take a group of students to Washington, D.C., to give them a real life experience with some of the history they are learning. One of our therapists is going to go with them.

4. REPORT OF THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES
Ms. Ruffin: I've asked Nancy to give the Directors Report, with one caveat. Since she wrote it, she left herself out of it. I wanted you to know that Nancy was very instrumental in getting the AB 2034 money.

Ms. Presson: And thanks are due to lots of people who were involved, including our advisory group.

1. AB 2034—We received a formal allocation letter from the State Department of Mental Health last Thursday awarding San Francisco $2.3 million dollars a year to provide services to the homeless mentally ill. The award is about $300,000 less than our proposal requested.

CMHS is developing a work plan that reflects the reduced amount. The dollars will fund the expansion of the MOST Team to provide intensive case management to 120 homeless mentally ill individuals and develop 55 units of housing for this population.

Steve Mayberg, Director of the State Department of Mental Health praised the San Francisco proposal for its single focus and the strength of its collaborations. The State was impressed that the proposal and the interview demonstrated our ability to implement quickly and provide data for the Department and the legislature. Thanks to Louise Rogers for planning and writing the grant, to Blanche Korfmacher and Linda Wang for providing leadership in this effort, and to the community and government representatives who assisted in development of the proposal.

2. New Medical Director—We are pleased to announce that Dr. Robert Cabaj has accepted the position of Medical Director for Community mental Health Services. It's quite a coup to have him come up to us from San Mateo. He lives in the City and was interested in being part of the city system.

Dr. Cabaj has extensive experience in overseeing community mental health systems. He has recently served as medical director for San Mateo County Communality Mental Health and is on the faculty of the University of California San Francisco. He is skilled in addiction medicine and has experience with HIV focus programs and child mental health programs. Dr. Cabaj is expected to start mid-December. He already knows a lot of the physicians in our system and people speak highly of him.

3. California Endowment Initiative for Mental Health—Last month we alerted you to the California Endowment Initiative for Mental Health Programs. CMHS has worked with the Department of Public Health primary care leaders to submit a proposal for integrated behavioral health services at primary care sites. The Proposal calls for increased psychiatric and social work time at two additional City & County primary health care sites based on a local planning process at the site and will result in training for primary care staff to identify behavioral health issues. I also provided letters to support applications submitted by Richmond Maxi Center, Larkin Street Youth Services, Edgewood Services, and IMCares. IMCares is a branch of the machinists union, which works with CalWorks.

4. 2000/20001 Budget—The Department of Public Health Budget Committee has started to plan for the 2000/01 budget year. Community Mental Health Services executive staff developed a list of initiatives needed to implement the mental health systems of care to submit to the Population Health and Prevention planning. Many of the requests require collaboration across sections of Population Health and Prevention and the Community Health Network including supportive housing and treatment bed initiatives, increasing CMHS urgent response to reduce PES and hospital visits, and increased case management.

5. Napa State Hospital—This summer we increased Napa Beds for San Francisco by three beds to a total of 38. It was apparent that the number of beds for clients who needed containment in a long term locked setting were beyond the SF allocation. The Bridge Committee purchased an additional bed for a Laguna Honda patient. This makes 39. In the past six months 8 residents of the State hospital system placed through the criminal justice system have completed their justice obligation and were found to continue to require state hospital placement through the evaluation process by the San Francisco Public Conservator's office. In addition, Children's Services continues to purchase three children's state hospital beds at Metro State Hospital due to delays in licensing the Children's Treatment Facility (CTF) operated by Seneca on the campus of the Mental Health Rehabilitation Facility. State hospital beds are far away for case managers and families and are expensive ($112,000-$132,000 per bed/year.) We will continue to monitor the needs of our community for Napa beds and alert you of the potential budget problems due to placements in the state hospital system.

6. The Mental Health Forum has identified key principles for the Adult Mental Health System for clients who utilize emergency and acute services. There is general agreement that case management and appropriate community placements are key ingredients in the System of Care for these clients. Discussions point to levels of case management needed for these clients. We have started to map what is available and what are the needs given the size and complexity of the population. Similarly we are reviewing the resource gaps for community and long-term care placements by identifying the current barriers to placement for clients in the hospital, long-term care and residential treatment. From this information we can develop a budget proposal to reduce institutional use for those individuals ready for placement at a lower level of care.

7. Good news! The San Francisco Children and Families Commission approved an additional allocation of $650,000 in Proposition 10 dollars to expand the CMHS

Children, Youth and Family Service's Childcare Mental Health Consultation and Service Program.

Ms. Ruffin: We have another piece of good news. We have revised our application for our SAHMSA block funding because we've gotten an increase in our allocation, which increased our grant amount by $672,290 in ongoing dollars and gave us $171,477 in one-time monies. What we have done is to take a look at some of the resource needs we have for taking care of adult and child long-term clients. On the copy of the grant which you have before you, you can see the specific items we are proposing to fund.

Dr. Moses: Going back to the Director's Report for a minute, on number 5, towards the end, it says that state hospital beds are far away. What is the long-term goal to address that issue? Is it possible to expand some of the programs we have locally?

Ms. Ruffin: We have done that in the past. That's really been the building block of our system, to develop alternatives to Napa State Hospital. For the past 7 years we have very consciously tried to reduce our beds at Napa and move those dollars to community programs, into the operation of the MHRF, to increase the intensive case management programs and some of the residential treatment alternatives, and to create additional patches to the Board and Care system. So we've actually reduced the number of beds a lot. When we first started, before I was director, we had 297 hospital beds, and now we are down to 39. That reduction was also connected to the realignment of State hospital funding. Those funds used to be held by the state only for hospital beds, then it was given to the counties to use as they thought best.

Ms. Harrison: Are the beds on the 7th floor of SFGH, just for people from PES?
Ms. Ruffin: We consider those the main source of psych inpatient care. We also contract with some of the private hospitals for beds. This was part of our taking over authorization of inpatient care under managed care consolidation. We're always trying to create more community alternatives to the high-end system.

Ms. Harrison: I'm so thrilled that we're enhancing MOST. They are a joy to work with. They will go anywhere.

Ms. Traveler: About increasing the services for Filipino families, does that mean that the needs of Filipino families have increased or have they always been there and the community has just been underserved? Ms. Ruffin: The needs have been there. And we are increasing a staff who has been working closely with the Filipino community from part time to full time. The South of Market Clinic has a Filipino team and we're looking to increase their services, too.

Dr. Beauford: Regarding the SAMHSA grant, we've already reviewed this grant, but now we are reviewing it again based on the increased dollar amount. Ms. Harrison: The Filipino community is in the grant. Are we also serving the Samoan community or are they also underserved? Ms. Ruffin: I think we are underserving them, we don't have a dedicated, focused program. But we have a number of Samoan adults and families in treatment.

Dr. Beauford: This increased grant is an opportunity to put some money into prevention and long-term care linkage, which is something we've been supporting.

RESOLUTION (MHB-00-34)
Be it resolved that the Mental Health Board send a letter to Jo Ruffin, Director, Community Mental Health Services, stating that the Board has reviewed the special CMHS renewal proposal for the 2000/01 block grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), which includes an increase of $171,477 in one-time dollars and $672,290 in on-going dollars, and that the Board gives its full approval and support to this grant. (Passed.)

5. REPORT OF THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD

Ms. Brooke: In your packet is something that says Annual Retreat 2001. The Executive Committee asked that we start the process now to look at what the Board will focus on as priorities for next year. On the list are the recommendations from our Annual Report last year and a couple of things we asked Jo and Nancy to add in. Please return these by the Board meeting in December.

Good news about the Retreat. The Executive Committee wants to invite Sue Bierman to work with us at the Retreat on how to be successful working with city leaders. She'll join us for lunch and lead a session for us for an hour and a half to give us the inside scoop on working with the Supervisors.

The program reviews are done. It was an absolutely great job you all did.

Dr. Moses: I have a question about the hearing at the Board of Supervisors on the Bayview Hunters Point Foundation.

Ms. Brooke: What I heard was a lot of concern from the employees about the way some of the agreements are going. What I heard was just a sense that the overall BVHP administration was not taking a lot of employee issues seriously enough. What I said at the hearing was that the Mental Health Board does not get involved in individual contractors issues, but that the Board had reviewed one of the BVHP programs and was extremely impressed with the work of the staff.

Dr. Moses: One of the Board members of the BVHP Foundation, spoke so highly of Helynna. She did a really great job. It was really appreciated at BVHP.

6. STATE LIAISON

Mr. Shipley: Just a reminder that this weekend in Concord is the CALMHB training for MHB members. I encourage new Board members to attend. It's free. I'm going because I've been asked to be one of the trainers.

Also I watch the internet for statewide issues. I received an email from the California Network of Mental Health Clients who passed along the recommendations of Lanterman Petris Short Reform from the NAMI Bay Area Coalition, and we'll mail those out to you. Some of the things listed here we came up with last spring. It follows pretty much what our MHB recommendations were. That question of LPS Reform is not going to be going away. And it will probably be on the national agenda.

7. COMMITTEE REPORTS

Executive Committee:

Dr. Beauford: We received a couple comments from a couple MHB members on how to do program reviews, so we can have more consistency. We haven't had a handbook of guidelines before, but I think it's important to have some training so we can get consistency on the reviews, including the criteria you should use for assigning ratings.

Ms. Harrison: I had a great time doing the reviews, but didn't like being limited to this one block of time. Why aren't we doing reviews all year round? Ms. Brooke: Next year we'll be doing that starting in February. Dr. Beauford: I'd like to extend my personal gratitude to all the members. The program reviews are one of the most important things we do, and everyone has taken them very seriously and done a great job.

Mr. Agar: I would like to do a brief review of our visit to Crossroads. I want to commend the Board members who attended that. It was a very positive experience and very informational. I certainly want to recognize the Committee members who attended with gratitude and thanks. It was very helpful for us. It was a chance to ask some great questions. They gave us a tour, and they were most hospitable. They even fed us. I think our committee is committed to taking every opportunity we can to address the needs of special populations. About the proposed Annual Report scenarios, I think it could be good to send them out to all Board members and discuss the plan for the Annual Report at the retreat.

8. PUBLIC COMMENT

Ms. Keller: Now that the office of conservator services has been removed from DPH, and transferred to the new Department of Aging, how do you think that will impact on the accountability situation, and where will their reports be going?

Ms. Ruffin: The change was for the LPS Conservator's office to go under the Department of Aging, and to move the Public Guardian's office under the Department of Aging as well. There hasn't been any major change in our working relationship so far with the Public Conservator's office. It's still located here in this building. The Director of Aging is convening a working group that will include CMHS to figure out the reporting and planning procedures. Probably the report will go from the Conservator's office to my office and then on to the state.

Ms. Keller: I would be interested in a presentation from the Conservator's office. I've had some involvement there with more than one case about difficulties in getting proper treatment for paranoid schizophrenics. And it's extremely difficult in the county of SF when you have an adult person so diagnosed. When you ask the question, which I thought was a simple question, how does one go about getting an LPS conservatorship for such a person, the answer to me is always, "I don't know." I called and talked with staff in Marin and Alameda counties and asked the same questions and got real answers, but I can't get that same answer in San Francisco. Ms. Ruffin: On specific cases, my office would be glad to help, and our Office of Consumer Affairs will work with any case.

9. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:28 p.m.

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SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

MEETING OF THE FULL BOARD

Wednesday, December 13, 2000
1380 Howard, Room 537
6:30 p.m.

AGENDA:

1. **CALL TO ORDER, INTRODUCTIONS** 5 minutes

2. **CONSENT CALENDAR** (See Attachment A) 5 minutes
   a. PROPOSED ACTION: The Board approves November minutes
   b. PROPOSED ACTION: The Board approves leaves of absence for December

3. **PRESENTATION: FRANCIS LU, M.D., SFGH** 45 minutes
Francis Lu, M.D., Director of Cultural Competency and Diversity Programs, Department of Psychiatry, SF General Hospital, and Clinical Professor of Psychiatry at University of California, San Francisco, will present issues, concerns, and future projections regarding the culturally competent inpatient units at SFGH.

4. **REPORT FROM THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES** 30 minutes

5. **REPORT FROM THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD** 5 minutes

6. **REPORT FROM MHB STATE LIAISON** 5 minutes

7. **COMMITTEE REPORTS** 15 minutes
- Executive Committee, Chair's Report (See Attachment B)
  PROPOSED ACTION: The Board approves a Resolution in Support for Outreach to Families, specifically supporting the program Family Links to Mental Health.
- Additional committee reports as needed

8. **PUBLIC COMMENT PERIOD** 10 minutes

9. **ADJOURNMENT**

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MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Down-town Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

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mhb@igc.org
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MENTAL HEALTH BOARD
ATTACHMENT A

December 13, 2000

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed.

A. Approve Minutes of Prior Board Meeting

RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of November 8, 2000, be approved as submitted.

B. Approve Requested Leaves of Absence

Additional requests may be added at the Board meeting.

RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of December 13, 2000, to the following members: Renee Deger, Peggy Gilleran..

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MENTAL HEALTH BOARD
ATTACHMENT B
December 13, 2000

FAMILY LINKS TO MENTAL HEALTH

This program was established during the last year with $270,000 of funding initiated by Supervisor Leland Yee and passed by the Board of Supervisors. Because the program is a complicated one and it has taken time to find someone with the right qualifications to hire as director, the start up has been slower than originally planned.

There is some concern now that the program won't be continued in the proposed budget for 2001/02. However, both the Mental Health Board and CMHS have been putting a strong focus on bringing in family members as partners in treatment programs for children and adolescents.

The purpose of this resolution is to provide support for the continuation of Family Links. Attached is detailed information on the scope of the program.

RESOLUTION (MHB-00-xx)
SUPPORT FOR OUTREACH TO FAMILIES

WHEREAS, it has been shown that including immediate and extended family members as partners in the treatment of mentally ill children and adolescents produces significantly better outcomes, both in terms of the result of treatment and in terms of reducing the ultimate cost of treatment, and

WHEREAS, the Child, Youth, and Family Section of Community Mental Health Services has been demonstrating continued success with family inclusion, and

WHEREAS, the urgent need has been identified for proactive system of outreach to families citywide, and

WHEREAS, the Department of Public Health has provided initial funding for a new program, Family Links to Mental Health, to provide families with assistance on accessing services, to bring them into partnership with treatment programs, and to provide them with other resources and information they need, and

WHEREAS, the sponsoring agency, Support for Families of Children with Disabilities, has a track record for providing excellent and effective family-oriented programs, now, therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board recommends continued funding and support for Family Links to Mental Health under the auspices of Support for Families of Children with Disabilities.

Children's Mental Health Initiative

Exhibit A

1. **Agency and Program Identification:**

Support for Families of Children with Disabilities
2601 Mission Street, Suite 804
San Francisco, CA 94110
Contact: Juno Duenas, Executive Director

2. **Nature of Document:** New 1999/2000 Contract: April 1, 2000 - March 31, 2001

3. **Target Population:**

Families in San Francisco who have mental health issues or concerns and who have a child ages birth through 17 (or to age 22 if the child has special needs and is still in school) will be the focus of this project. These issues are characterized by alterations in thinking, mood, or behavior that cause distress or impair ability to function, and include depression, attention-deficit or hyperactivity disorder, among others. These families are found in all ethnic groups, gender groups, age groups, sexual orientation groups, and neighborhoods.

The recently issued report on mental health by the U.S. Surgeon General states that 22% of the population, including one in five children, has a diagnosable mental disorder, but that nearly 2/3 of these people do not seek treatment. Reasons for not seeking treatment include cultural stigma about mental illness, lack of insurance, and highly fragmented service systems which make access difficult.

San Francisco's population of 742,000 is one of the most ethnically diverse in the nation with large numbers (86,000) of non- or limited English speakers and many uninsured families. This project will improve access to the mental health system for San Francisco families by providing a multi-lingual, multi-cultural parent-to-parent peer telephone Help Line, plus clinical support and services. Through this "family-friendly" access point, parents will receive information and peer support, professional consultation, and assistance in accessing services provided by the Department of Public Health and the San Francisco Mental Health Plan.

4. **Service Units**

- Peer Parents will make 400 individual contacts with families during the length of the project.
- Peer Parents will make 400 individual contacts with professionals during the length of the project.
- Clinical Staff will provide 1,400 ¼ hours of consultation to families during the length of the project.
- Clinical Staff will provide 1,400 ¼ consultations to professionals during the length of the project.
- Hotlines will make 500 contacts during off hours.
- On-call counseling will provide 147 hours of bi-lingual counseling support.
- Both Peer Parents and Clinical Staff will participate in 700 ¼ hours of cross training.

- Both Peer Parents and Clinical Staff will participate in 500 ¼ hours of outreach to the community.
- Create 4,000 brochures for outreach.

5. **Objectives:**
    5.1. By May 2000 Support for Families will **hire multi-lingual project staff**, including peer parents, a Licensed Clinical Social Worker, and Social Worker.
    5.2. Peer parents will provide **400 individual information contacts, referrals and/or family to family support contacts** in English, Spanish, and Cantonese, via the Parent Help Line and/or visits by parents to the SFCD Center. Support for Families will explore the best way to accommodate families who speak Vietnamese and Russian or other languages, including the use of paid parent mentors and or AT&T interpreters.
    5.3. Peer parents will provide **400 individual information contacts and/or referrals** to professionals in English, Spanish, and Cantonese, via the Parent Help Line and/or visits by professionals to the SFCD Center.
    5.4. Clinical staff will provide **1,400 ¼ hours of individual clinical consultation** to families via the Parent Help Line or visits by families to the SFCD Center.
    5.5. Clinical staff will provide **1,400 ¼ hours of individual clinical consultation** to professionals via the Parent Help Line or visits by professionals to the SFCD Center.
    5.6. **Hotline** consultants will coordinate services and provide 500 contacts during off hours.
    5.7. **On-call counseling services** will provide will provide 147 hours of bi-lingual consultation.
    5.8. Project staff will develop plan and implement **cross training** to peer parent phone line staff, clinical staff, and other hot line providers in **700 ¼.** hours.
    5.9. Project staff will develop plan and implement plan for **outreach activities** to families, community-based organizations, city departments, and community groups to promote the Help Line services in **500 ¼ hours**. Promotional activities will devote particular attention to underserved cultural and linguistic communities.
    5.10. Project staff will develop **4000 brochures for outreach** and distribute them throughout the community. Brochures will be translated in Spanish, Chinese, Vietnamese and Russian.
    5.11. By the end of June 2000, project staff will have developed **an infrastructure improvement plan** for additional phone line equipment and/or database resources that may be needed to improve family access and maintain accurate monitoring of the program.
    5.12. By the end of June 2000, Peer Parents will conduct 3 month **follow-up** phone contacts with 25 families who called the Help Line during March and April. A questionnaire will be developed for program partners and staff.

6. **Methodology:**
    6.1. **Staffing:** Support for Families will hire Peer Parents to complement existing Peer Parent phone line and drop-in resource center staff. A Licensed Clinical Social Worker will be hired as well as a Social Worker. The Peer Parent Supervisor will supervise the other Peer Parents. The Licensed Clinical Social Worker will be supervised by the Director of Support for Families and will supervise the Social Worker. The Peer Parent Supervisor,

the Peer Parents will work closely with the Licensed Clinical Social Worker and the Social Worker to ensure sharing of expertise. Job descriptions and job announcements will be developed. Outreach for potential staff will include flyers, on-line recruiting sites, and job boards.

6.2. **Peer Parent Individual Family Contact Information and Support:** The Center is located at 300 Seneca Avenue and is co-located with the San Francisco Unified School District Department of Special Education Intake Unit as well as other agencies. Peer Parents will be available by phone and drop-in during the following days and hours: 9:30 – 4:30 Monday through Friday and till 8:30 PM Tuesdays and Thursdays. Spanish and Cantonese multi-lingual access for families will be available through the peer parent staff. Support for Families will explore using Parent Volunteer and or AT&T interpretation services for other languages. An intake form with identification information and presenting issues will be completed on each family who calls or visits the Center. Contacts will be tracked. Peer Parents will provide information, referrals and parent to parent support, as needed.

6.3. **Peer Parent Individual Professional Contact Information and Support:** Individual Peer Parents will be available by phone and drop-in during the following days and hours: 9:30 – 4:30 Monday through Friday and till 8:30 PM Tuesdays and Thursdays. Spanish and Cantonese multi-lingual access for families will be available through the peer parent staff.

6.4. **Clinical Consultation for Families** will be available to families during the hours outlined under 6.4. Peer Parent Support. In addititon The LCSW or Social Worker will be available for off hours emergency support via a pager. Clinical support for non-English speaking families will be provided via contract with other bi-lingual professionals. Clinical staff will maintain forms with identification information and presenting issues on each family who calls or visits the Center. .

6.5. **Clinical Consultation for Professionals** Clinical consultations will be available for peer parent staff, other professionals and the community at large. Consultations will include information about services, consultation in behalf of families, gaining access to services for families. These consultations will be tracked through a log that the Clinical staff maintain.

6.6. **Infrastructure Improvements:** Support for Families will develop a plan to use technology to work more effectively. This plan will detail phone and computer equipment needed as well as a plan to transfer data that is now being kept in paper files to a networked computer system. They will hire consultants to implement the plan.

6.7. TALK Line, CHALK Line, Suicide Prevention Line, Asian Pacific Islander Family Hotline will provide **Hotline consultation** and off hour **500 contacts** which will include referrals, consultation to family members and professionals to provide a network of support in San Francisco.

6.8. The project will contract with individual professionals to provide **on-call bi-lingual services**.

6.9. **Cross Training:**

Cross training will include providing training and coordination of services between Support for Families/Parent Help Line, TALK Line, CHALK Line, Suicide Prevention Line, Asian Pacific Islander Family Hotline, Community Mental Health Services as well

MENTAL HEALTH BOARD OF SAN FRANCISCO

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San Francisco, CA 94103
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13/00

UNADOPTED MINUTES

Wednesday, December 13, 2000, 6:30 p.m.
1380 Howard, Room 537

BOARD MEMBERS PRESENT: Chet Villalba (Vice Chair); Tim Agar; Bridgett Brown; Marushka France; Andrea Leung, L.C.S.W., A.C.S.W.; Mickey Shipley; Lora Traveler;

BOARD MEMBERS ON LEAVE: Jim Beauford, Ph.D. (Chair); Scott Ruble representing Supervisor Sue Bierman; Peggy Gilleran, J.D.; Toye Moses, Ph.D.; Kate Walker.

BOARD MEMBERS ABSENT: April Martin Chartrand; Pat Harrison; Brian Peagler.

PRESENTER: Francis Lu, M.D.
Director of Cultural Competency and Diversity Programs, Department of Psychiatry, San Francisco General Hospital

OTHERS PRESENT: Jo Ruffin (CMHS); Nancy Presson (CMHS); Norm Nickens (DPH); Emeric Kalman (Family member),Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Chet Villalba, Vice Chair, at 6:42 p.m. Mr. Villalba made the following two announcements: Supervisor Bierman has appointed Kate Walker. She's not able to be with us this evening, but will attend the Retreat in January. Renee Deger has resigned from the Board due to other commitments.

Mr. Shipley: I'd like for us to send a special thank you to Renee for being part of the coalition of NAMI groups in the Bay Area for the position they are taking on AB 1800, the LPS Reform Act.

2. CONSENT CALENDAR

RESOLUTION (MHB-00-35): Be it resolved that the minutes of the Mental Health Board meeting of November 8, 2000, be approved as submitted. (Passed)

RESOLUTION (MHB-00-36): Be it resolved that the Mental Health Board grant leaves of absence for the December 13, 2000, meeting to: Jim Beauford, Ph.D. (Chair); Peggy Gilleran, J.D.; Toye Moses, Ph.D., Kate Walker (Passed)

7. COMMITTEE REPORTS (Taken out of order.)
Mr. Villalba: We'll be starting with the committee reports since our presenter will be arriving at 7 p.m.

Program & Services Committee
Ms. Traveler: The Program and Services Committee has been working on the topic of women in prison. Our first meeting on the issue was an overview and our second meeting was with Sheriff Hennesey. At our most recent meeting, we didn't have a speaker, but we put together a folder about women in prison for the Board.

There has been this phenomenal growth of women in prison since 1970. There have been all these studies of how women in prison with mental illness are being treated. In 1970, there were 6,000 women in federal and state prisons, but by the mid 90's there were 75,000. The number has been growing at the rate of 11% a year. The packet comes from 3 sources: the National Alliance for the Mentally Ill, a report by the state prisons, and Jet magazine.

Fact #1: There are over 90,000 women in prison in the United States today.

On an average day, said Linda A. Teplin, a professor of psychiatry at Northwestern University Medical School, 9% of men and 18.5% of women in local jails—about 56,000 prisoners—are severely mentally ill.

Fact #2: Of the women convicted of violent crimes, the vast majority were convicted for defending themselves or their children from child abuse.

On any day, almost 200,000 people behind bars—more than 1 in 10 of the total—are known to suffer from schizophrenia, manic depression or major depression, the three most severe mental illnesses. The rate is four times that in the general population.

Fact #3: 54% of women in prison are women of color.

"There is a long-standing association between poverty and crime," says Dr. Barbara Scott, a professor of sociology and women's studies at Northeastern Illinois University and Chair of NIU's departments of criminal justice, social work, sociology and women's studies. "When you factor in race and gender, it's even more prevalent because there is a disproportionate percentage of African Americans who are poor. Women are disproportionately poor compared to men and black women are far more disproportionately poor than other groups of women."

Fact #4: Ninety percent of women in prison are single mothers. They lose contact with their children, sometimes forever. There are 167,000 children in the United Sates whose mothers are incarcerated.

Ms. Akanni, for example became upset when she could not find her 2 year old daughter; the child had fallen asleep under a bed. To calm herself, Ms. Akanni went for a drive, but she got in an accident. When she gave her name as the Lord God Almighty, an officer arrested her for drunk driving. A week passed before a psychiatrist saw her and she was able to explain that she had a 2 year old at home alone. When Ms. Akanni was released, she was arrested again for abandoning her child. The girl had survived by eating garbage.

Fact #5: The average age of women in prison is 29, and 58% have not finished high school.

Without the state hospitals, experts say a revolving door has been created, in which many mentally ill young people cycle from clinics to homelessness to jail.

Fact #6: Racism and economic discrimination are inextricably linked to sexism in our culture, creating severe inequalities in the court system. For example, Black women are twice as likely to be convicted of killing their abusive husbands than are white women. Black women, on average, receive longer jail time and higher fines than do white women for the same crime.

The disparity in earnings that still exists between women and men in general, and for Black women in particular, known as the feminization of poverty, is a likely cause for that upsurge.

Fact #7: 25% of political prisoners are women.

Misdemeanors are the leading charges against people with severe mental illness. Mentally ill inmates are three times more likely to have been charged with disorderly conduct, five times more likely to have been charged with trespassing, and 10 times more likely to have been charged with harassment.

Fact #8: The number of women in prison has increased 138% in the last ten years. This is partly due to the worsening of economic conditions for women, and also due to the increase in arrest rates due to the "war on crime" and the "war on drugs."

"Many of the women we speak of are victims of triple jeopardy—class, race, and gender oppression." Dr. McGee says. "Many of the female offenders have been victims themselves and the problem is that our society is not willing to address these different layers of victimization. As a result, she is being processed and labeled as a new violent offender. In many cases, she is not."

Fact #9: Women prisoners spend on average 17 hours a day in their cells, with one hour outside for exercise. Compare to men prisoners, who spend on average, 15 hours a day in their cells, with 1.5 hours outside.

But even as the Los Angeles jail moves toward, in effect, creating its own mental hospital, there are still problems inherent in dealing with the mentally ill in any jail. "Inmates," said Kunzman, the former medical director, "are seldom in jail long enough to stabilize them on the right medication, and offer them adequate therapy or to plan for their care after release."

Fact #10: The Women's High Security Unit at Lexington, Kentucky, was closed in 1988 because of a national and international human rights campaign. The prison kept the women in years of isolation in subterranean cells, conducted daily strip searches, allowed extreme sleep deprivation practices, and as policy condoned a complete denial of privacy, including male guards watching the showers, and an intense campaign of sexual abuse.

Advocates for the mentally ill say the clock is being turned back to the 19th century, when it was common in the United States to confine people with mental illnesses in jails. Mental hospitals and asylums grew out of a crusade in the 1840's by Dorothea Dix, the Boston reformer, who warned that "insane persons" were being confined in "cages, closets, cellars, stalls, pens; chained, beaten with rods, and lashed into obedience."

Ms. Traveler: This is certainly something that we need to be aware of as a Board. And it is having tremendous impact on the poor. I hoped this handbook would bring to your attention what is happening in the prisons, because it is extremely serious.

Executive Committee

There was a discussion in which Board members emphasized how important it is to provide services to the full range of communities in our city, including all minority communities, and to provide services for the full age range of transitional youth.

Ms. France: Family members are the first line of support and I certainly understand that it would be hard to find a director. We should support a well thought out program.

RESOLUTION (MHB-00-37)
SUPPORT FOR OUTREACH TO FAMILIES

WHEREAS, it has been shown that including immediate and extended family members as partners in the treatment of mentally ill children and adolescents produces significantly better outcomes, both in terms of the result of treatment and in terms of reducing the ultimate cost of treatment, and

WHEREAS, the Child, Youth, and Family Section of Community Mental Health Services has been demonstrating continued success with family inclusion, and

WHEREAS, the urgent need has been identified for proactive system of outreach to families citywide, and

WHEREAS, the Department of Public Health has provided initial funding for a new program, Family Links to Mental Health, to provide families with assistance on accessing services, to bring them into partnership with treatment programs, and to provide them with other resources and information they need, and

WHEREAS, the sponsoring agency, Support for Families of Children with Disabilities, has a track record for providing excellent and effective family-oriented programs, now, therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board recommends continued funding and support for Family Links to Mental Health under the auspices of Support for Families of Children with Disabilities. (Passed.)

3. PRESENTATION: FRANCIS LU, M.D.

Mr. Villalba: Francis G. Lu, M.D., is Clinical Professor of Psychiatry, University of California, San Francisco. He is also the Director of the Cultural Competence and Diversity Program, Department of Psychiatry at San Francisco General Hospital, where he has worked for over 23 years. He is the founder of the Asian/Pacific American Psychiatric Inpatient Program, which served as a model for 5 other programs serving Black, Latino, Women, Gay/Lesbian and HIV patients. In 1987, the American Psychiatric Association (APA) awarded the Ethnic/Minority Psychiatric Inpatient Programs at SFGH a Certificate of Significant Achievement. He currently serves on the National Advisory Council of the Federal Center for Mental Health Services, the California State Department of Mental Health Cultural Competence Advisory Committee, and the UCSF Chancellor's Committee on Diversity.

Dr. Lu: Every person is in certain respects: 1) like all other people, 2) like some other people, and 3) like no other person. This is where we are starting from with cultural competency.

The mission of the Department of Psychiatry is to provide the highest quality care to individuals with severe mental illnesses, especially those from ethnic and other minority groups, who largely depend on the public sector. In support of this and to further the academic collaboration between the City and the University, the Department is committed to providing training and to conducting research and evaluation of services that will enhance the treatment of consumers of our services.

The Cultural Competency and Diversity Program, was organized in 1995 formally, but really started in 1978. Since the 80's we developed these task forces, which meet on a monthly basis to advocate for services. We are now developing a Spirituality Task Force which I am personally interested in.

We are at the intersection of different systems. We are within the San Francisco General Hospital complex, we're part of the Community Health Network of DPH, and part of the University of California San Francisco, which means we have residents, and medical students, and psychology fellows. SFGH and UCSF have a relationship that is over 100 years old. We provide 75-80% of inpatient care for city mental health services.

I've made this Department my career because of the public psychiatry aspect, the diversity aspect, and the training aspect. The training is a very important part of the work there. I started at SFGH in 1977 on Ward 7C. President Carter in the late 70's set up a commission on mental health which Rosalyn Carter chaired. In the report, they talked about the concept of bringing together scarce human resources into teams to provide services across catchment areas. At that time San Francisco was divided into 5 districts or mental health systems. At that time 22% of the city was Asian, and now it's up to 36%. The idea was to link an Asian focus inpatient unit with the Asian outpatient treatment centers which were already in existence.

The Surgeon General, in his December 1999 Report, said, "Without culturally competent services, the failure to serve racial and ethnic minority groups adequately is expected to worsen, given the huge demographic growth in these populations predicted over the next decades." The issues President Carter's Commission named continue to the present.

The concept of our focus units includes the following: 1) Focus on underserved populations; 2) Bring together multidisciplinary staff, faculty, and trainees to work with focus patients; 3) Goals: services, training, research; and 4) Focus is not segregation.

The unit chief of our black focus unit is a black psychiatrist from South Africa, who trained in Harlem Hospital. We were able to recruit him to San Francisco in 1995, and I think the focus units were one of the reasons he came here, and continue to be one of the reasons he's stayed. It's not that easy to recruit staff.

I was the unit chief of 7C when we started the Asian Focus Unit in 1980. In 1983, we started the Women's Issues Focus Team, the Latino Focus Team, and the HIV/AIDS Focus Unit. In 1985 we started the Black Focus unit. In 1992 we started the Lesbian/Gay/Bisexual/Transgender Focus Team.

Fourteen Asian languages and dialects of Chinese are spoken by our staff right on the unit. Most of them are immigrants themselves and know what that experience is like firsthand. Most common Asian language is Cantonese. We have a Cantonese speaking psychiatrist, nursing staff, occupational therapist, MSW, and unit clerk. So the multidisciplinary language capability is right there on the unit.

With regard to the DSM-IV, there are lots of innovations that we've incorporated into our work. I'm proud to say that I was one of the people who helped change the DSM-IV. This is not a diagnosis, but one of the additional considerations.

> Ethnic and Cultural Considerations: "Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience, that were particular to the individual's culture....It is hoped that these new features will increase sensitivity to variations in how mental disorders may be expressed in different cultures and will reduce the possible effect of unintended bias stemming from the clinician's own cultural background."
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> DSM-IV Religious or Spiritual Problem: "This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution."
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> DSM-IV Outline for Cultural Formulation:
> A. Cultural identity of the individual
> B. Cultural explanations of the individual's illness.
> C. Cultural factors related to psychosocial environment and functioning.
> D. Cultural elements of the relationship between the individual and the clinician.
> E. Overall cultural assessment for diagnosis and care.

CMHS in association with the California Institute of Integral Studies, recently held a conference on spirituality and mental health. No one would have thought of that ten years ago.

It's also very important to understand ethnic variations in psychopharmacology.

Karl Jaspers, in his book *General Psychopathology*, published in 1914 said, "Psychopatholgy is concerned with the ill person as a whole...We must, therefore, as scientists, keep an open mind for all the empirical possibilities and guard against the temptation to reduce human experience to one common denominator."

Training is a key part of our program. People come to us because of our focus programs, then from that group of medical students we are able to recruit medical residents into our psychiatry training program. And we work hard to recruit residents who want to work with the underserved populations. We have sixteen residents. Ken Gee, for example, was a medical student, and then a resident in 1985. After he graduated, he became a Unit Chief and has stayed with us for ten years. Many other clinicians in our system were recruited through our training program and because of our focus units.

With regard to the status of programs at this point, there was some questions about keeping them open. In the spring of last year, there was a meeting between DPH, CMHS, and the Mayor's Office, to try to keep all the units funded as long as certain performance measures are maintained.

We are currently meeting those measures. We are bringing in $1.8 million in revenue per year. We are reducing the length of stay. It is down to 13.9 days from 15 days (excluding a small number of clients who have extraordinarily long stays.) We're meeting the requirement for having a mix of funding. We're keeping the percentage of patients admitted from Psychiatric Emergency Services steady. And we are diverting most out of county patients.

So in terms of the future, the hope is that as long as we are meeting our performance measures as agreed upon, that we will be able to continue to provide these inpatient services to the city, and we look forward to continuing to work with CMHS to do this. We don't know exactly what's going to happen, but we are hopeful and confident.

Ms. France: Is the length of stay determined primarily by the physician or budgetary concerns?

Dr. Lu: Lots of factors go into that. The decision is made in teams with the psychiatrist as the ultimate authority. We make the clinical determination first. The other piece is what are the available dispositions for patients, are there dispositions which are alternatives if the optimal dispositions are not available. We work with the CMHS Bed Committee to see what would be the best place for care. We have situations where patients need to wait for an opening in a long term facility. The demand is greater than the supply. Some of those waits can be a long time.

Ms. France: I'm very excited about the spiritual focus. I think that's wonderful. Would it also include people who are, for example, a Chinese Taoist, who is having a crisis because a sibling or child is becoming a Christian. Or a Catholic who's converted to an Eastern religion?

Dr. Lu: Yes, those are excellent examples. Also we work with people who are changing denominations, or having questions of faith. And they need sensitive care, recognizing the importance of these issues, and then clarifying the religious or spiritual interventions that might be helpful for this person. This does not at all obviate the other aspects of care. The person could have major depression, but in addition the person might have a feeling like God is abandoning them, and this is another aspect of the person's stress. If we paid more attention to these religious and spiritual issues, maybe that would help with the overall outcome.

At SFGH, we have the Sojourn Ministry, a multi-faith ministry. We have a number of ministers and trainees coming into the units. I serve on the Board of Sojourn. There is more to be done, but good things are happening.

Ms. Traveler: I want to thank you for an excellent presentation. Is the $1.8 million in revenue federal and state money? Dr. Lu: Yes, I believe so. We have no private insurance at the hospital.

Ms. Traveler: You came in 1977, under President Carter. We're still suffering in California because of the way the State hospitals were closed without enough community clinics. What was very exciting to me was having Tipper Gore who was right on regarding the needs of the mentally ill. What impact will the new President have on programs like yours?

Dr. Lu: At the federal and state levels I think cultural competency is established. On November 22nd, President Clinton signed a law called the Health Disparities and Minority Health Research and Education Act, which establishes the issue of health disparities in the National Institutes of Health in very important ways. NIMH has a strategic plan on the website, with regard to health disparities and mental health. (http://healthdisparities.nih.gov/working/institutes.html)

Mr. Agar: Thank you, too, for your presentation; it's been very interesting and helpful. What's the time line for your implementation of the Spirituality Task Force. Dr. Lu: We're meeting tomorrow and hope to have it up and running in the next month or two.

Mr. Agar: In your definition in the DSM-IV, would the religious based guilt and shame issues from a conservative upbringing be in this area?

Dr. Lu: Take the case of someone who is homosexual and had a Catholic upbringing, who was thrown out of the church, but who would like to be part of the church. I think you could categorize that as a spiritual or religious aspect of the problem. And then the question is how do you address that with spiritual or religious interventions and with social interventions to help that person link up with other people going through similar problems.

Mr. Villalba: But a person who may be diagnosed as paranoid schizophrenic or seriously mentally ill, who is having religious ideations, is not part of this, is that right?
Dr. Lu: That's right.

4. REPORT OF THE DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES

Ms. Ruffin: We are revising our organizational chart. We used to be split along Adult Community and Managed Care lines. I'm trying to move the adult services into an integrated system of care, and I've asked Linda Wang to assume that responsibility. And I've asked Nancy Presson to be my Assistant Director for CMHS. She will continue to oversee risk management and the implementation of the mental health plan. Our new Medical Director, Dr. Robert Cabaj, will be starting on January 3rd.

I appreciate Dr. Lu mentioning the conference on spirituality and mental health. At least 250 if not 300 people were there. We'd like to turn this into an annual event. Nancy will now give the Director's Report.

Ms. Presson:

1. RFQ FOR COUNTY ASSESSMENT ON AT RISK CHILDREN AND YOUTH

:The Children's System of Care has issued a Request for Qualifications to find a provider to gather county data on unmet needs with regard to at-risk children and youth who have both substance abuse and mental health issues. We expect a contract award in January 2001.

2. TRANSITIONAL HOUSING AND SERVICES FOR YOUTH AGING OUT OF FOSTER CARE

One of our identified needs is housing and services for the youth who no longer qualify for children's services and have "graduated" from foster care protection. Seneca Center is attempting to buy a building in downtown San Francisco for an after-care site for approximately 20 youth who were in foster care. The youth would be enrolled in their training program to learn cabinet making and construction skills. Gastonell Group Home is also developing an after care program for approximately 18 youths who are no longer eligible for foster care. Additionally there is a group of private investors who may fund a transitional housing project. Community Mental Health supports these efforts and seeks to assist in development of funding strategies for these needed programs.

3. ELI LILLY PHARMACEUTICAL GRANT:

CMHS has been meeting with representatives of Eli Lilly Pharmaceuticals to explore the possibility of their awarding a grant to fund a medication compliance study. The original amount was $200,000. The idea for the proposal was developed originally by the Medication Compliance Taskforce, a workgroup composed of CMHS staff, consumers, and providers. The study would fund a clinic to employ peer outreach workers and self-help strategies to support consumers with medication follow-up and compliance, using a model called Directly Observed Therapy. The same model has been used by the Department of Public Health and shown to be successful in increasing medication compliance for individuals with TB. We are hopeful of hearing whether or not we will receive the award sometime within the next month.

4. MULTICULTURAL STUDENTS STIPEND AWARDS
CMHS awarded twenty-one Multicultural Student Stipends, ranging in amounts of $1,700 to $3,000 for this academic year 2000/01. The Multicultural Student Stipend Program is designed to assist students interning at our various mental health programs, in their development of skills to work with culturally diverse populations and to increase the pool of applicants with special skills and knowledge, including language, culture, and disabilities, for future employment with CMHS. As part of CMHS's human resource development commitment, the program is aimed at providing support to students interested in working with populations for which there is a shortage and need for culturally competent personnel resources.

5. NEW HOUSING RESOURCES FOR THE MENTALLY ILL
The Housing and Urban Health Section with CMHS has issued a request for proposals to operate two hotels and a residential care facility to serve DPH clients. The proposals have been reviewed and we are expecting an announcement within the next week. The residential care facility can serve non-ambulatory clients with some medical needs. There will be Asian language capability. CMHS has identified potential clients currently in long term care placements that could benefit from this setting. The hotels will be available to the homeless mentally ill clients enrolled in the new MOST case management program.

6. BUDGET
The Department of Public Health is in the middle of the budget process for 2001/02. The Department submission is reviewed by the Health Commission in February. CMHS has reviewed problem areas for the budget and targeted an increase in State realignment dollars for mental health to cover shortfalls in Medicare payments and costs for increased Napa State Hospital usage. In addition the Washburn Hotel, a valuable resource for housing the mentally ill, will lose its HUD funding and require County dollars to continue. CMHS has identified with contractor and County-operated clinic input, needs for 2001/02, but new dollars will be difficult to obtain.

Mr. Agar: Who does CMHS use as its resource for human studies? Ms. Ruffin: We have a Human Studies Committee set up in CMHS. Bill McConnell oversees the committee. It is comprised of some people from within the Department and some people from outside the Department. We have a series of requirements that must be met for human studies. Mr. Shipley: I am a member of the compliance task force.

Ms. Traveler, we did a site visit to Crossroads and found that one thing the young people needed was BART passes, because though they are in San Francisco, the closest station is in Daly City and the San Francisco Fast Pass won't work there.

Ms. Presson: Our SAMHSA grant budget has some flexible funds for transition youth. I can bring that idea to Linda Velasquez who oversees our transition services.

Mr. Villalba asked about coordination when a person is discharged from inpatient to outpatient. Ms. Presson: I think this is one of the reasons that leads us to believe that we need an integrated system. This is a very difficult problem, even when you have a good system.

Mr. Kalman: I have to give you some good news. I see the Board of Supervisors is in the process of approving $4 million dollars for CMHS. Ms. Ruffin: Those are the grant funds award by the state for the homeless mentally ill program under AB 2034.

Mr. Kalman: My question is, Are there any state or federal funding grants which were not discovered by the City of San Francisco, we didn't apply for, so we lost that money? Ms. Ruffin: Not that I'm aware of. There are lots of grants. We try to keep track of them. There is a grants office in DPH which screens for grants which are applicable to San Francisco.

Ms. Ruffin: One more item about the budget. We have had some indication that we probably will not receive more funding next year apart from the new AB 2034 money. So new initiatives beyond what we've identified are probably going to be very difficult next year. I do think there are a number of outstanding programs like the one in your resolution tonight, Family Links. That's an example of a Supervisor adding a one-time item to our budget, but there's no continuing money in the budget. So this is very helpful for you to propose continued funding.

Ms. Ruffin: The Coalition on Homelessness had a rally at the Civic Center and the Health Commission meeting. They are asking for full funding for the Police Crisis Intervention Project. They haven't been able to come to agreement with the Police Department over that. The Coalition was also urging no expansion of involuntary treatment laws. They are expecting that there will be another attempt at LPS reform in the legislature. They were also requesting mental health treatment on demand. I hope the Mental Health Board will take up the advocacy for mental health treatment on demand. Perhaps you could talk about it at your retreat.

5. REPORT OF THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH BOARD
Ms. Brooke: I hope everyone is working on your priorities and goals for 2001. Bridget won the honor of being first to turn hers in. This is the second time she's won such an award. She was the first to turn in her program reviews, too.

The Board of Supervisors has really changed. In talking with the person who handles appointments, it became clear that they have not figured out yet all the details of how they will transfer to the new district system. But your term is still the same length. We don't know the structure yet of the Rules Committee. We hope to meet with each of the new Supervisors to find out about their mental health agenda and have that information at the retreat.

6. STATE LIAISON
Mr. Shipley: I just got back last weekend from the annual client forum in San Diego. We had about 280 people attend. One of the speakers was Senator Chesbro, the Senate Budget Committee Chair. He's very much a friend of mental health. He reaffirmed that he will look at putting more money in mental health. He said he will look positively at the reform of LPS. He's very interested in more money for Community Services.

The Little Hoover Commission Report is out. It's very favorable to mental health services, but unfortunately it didn't mention a lot about consumers being involved at the state level.

The Client Forum focused on the same issues as last year, but we added in the issue of mentally ill women who go to jail and lose their children, or who are diagnosed and lose their children.

Also the membership approved a proposal I made to remove the word stigma from all our materials and replace it with the word discrimination.

We are staying with our position of non expansion of involuntary care. We really would like to see more community services. Senator Chesbro wants to see that, too.

7. COMMITTEE REPORTS

These took place earlier in the meeting.

8. PUBLIC COMMENT

Mr. Kalman: I have a copy of the Controller's financial report, and there is some bad news here. General Hospital is in the red $57 million. How I see it, we have to start with the Mayor and the new Board of Supervisors to make sure that we won't see some cuts next year. This is very serious. I keep an open eye and I will bring to your attention both the good and bad.

Ms. Ruffin: I wanted to mention Ashbury House, which is run by Progress Foundation It's a program for women who are mentally ill and who have children, and the model is working well.

9. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:39 p.m.

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